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ABSTRACT

The report is said to provide a plan for meeting the total needs (educational, personal, and vocational) of the mentally retarded for both service and residential living in Indiana. The plan proposes to bring the state hospital and community closer together and to offer several options that include the natural, foster, and small group home and the state hospital. Explanation of planning organization includes mention of Indiana Mental Health-Mental Retardation Planning Commission, Indiana Association for Retarded Children, and project administration. Program plan is reported to involve identification of problem, use of quantified objectives to overcome problem, establishment and implementation of plan, and evaluation periodically. Also covered in the report are statement of philosophy, residential models serving as alternatives to natural home, establishment and administration of demographic inventory of mentally retarded population, analysis of family care program, licensure of residential facilities, legislation, community education and participation, and recommendations concerning implementation of project plan, government agencies, family care, licensure, and legislation. Appended are papers pertinent to program plan, survey, family care, licensure, legislation, and guidelines. (CB)

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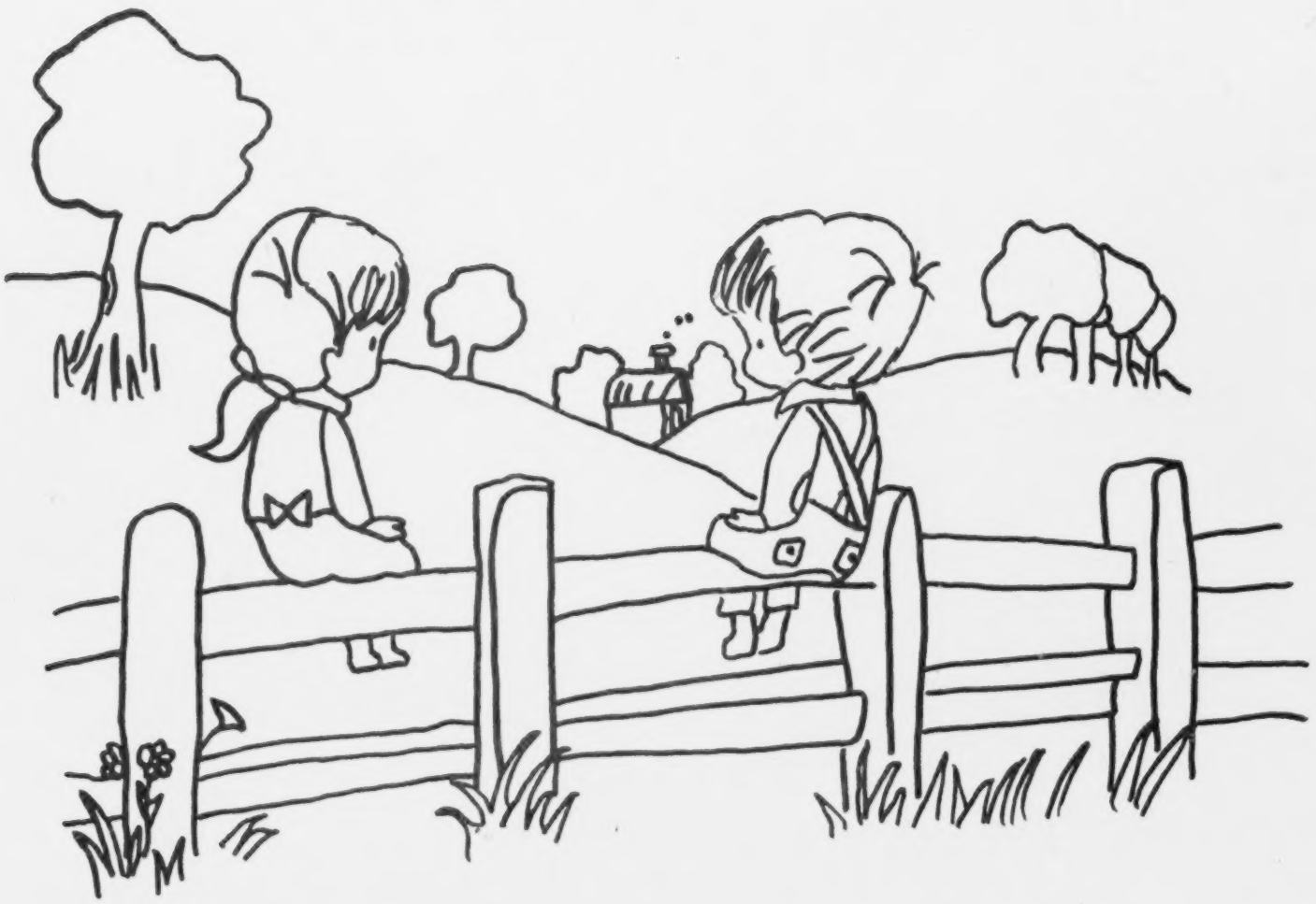
Our Human Resources



Indiana Mental Retardation Residential Services Planning Project

INDIANA

MENTAL RETARDATION RESIDENTIAL SERVICES

PLANNING PROJECT

FINAL REPORT

June 1970-June 1972

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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INDIANA MENTAL HEALTH - MENTAL RETARDATION PLANNING COMMISSION

FISCAL AGENT

INDIANA ASSOCIATION FOR RETARDED CHILDREN

"Discrimination Prohibited- Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.' Therefore all programs assistance from the Department of Health, Education and Welfare must be operated in compliance with this law."

INDIANA MENTAL HEALTH PLANNING COMMISSION

1315 West Tenth Street · Indianapolis, Indiana · 46207

June 30, 1972

The Honorable Edgar D. Whitcomb
Governor of Indiana
Indianapolis, Indiana

Dear Governor Whitcomb:

Here is the final report of the Mental Retardation Residential Study Project for your examination.

In our opinion this report fully justifies the two year's effort expended and will serve as a useful tool in implementing the recent legislation authorizing alternate care facilities for the retardate.

We appreciate your confidence in the Commission in assigning us the responsibility for the project.

Respectfully,

Thomas W. Binford
Chairman

INDIANA MENTAL HEALTH PLANNING COMMISSION

1315 West Tenth Street · Indianapolis, Indiana · 46207

June 30, 1972

Dr. Andrew C. Offutt
State Health Commissioner
1330 West Michigan Street
Indianapolis, Indiana 46206

Dear Dr. Offutt:

Here is the final report of the Mental Retardation Residential Study Project started two years ago.

We appreciate your confidence in the Commission in authorizing the grant by which the work was financed. In our opinion it is fully justified by the results, which should serve as a useful tool for implementing the recent legislation permitting alternate care facilities for the retardate.

Respectfully,

Thomas W. Binford
Chairman

FOREWORD

With the completion of this plan for meeting the residential needs of the mentally retarded a "new day" may be dawning in the lives of the several thousand mental retardates who require some assistance from society in order to participate in the economic and social life of the community. For over a century the mentally retarded who could not be cared for in their natural homes were forced to be placed in a state institution with little hope of being habilitated for return to the community where they could lead a normal life within their mental and physical limitations. There were no other options.

For a decade or two through the efforts of parent organizations, with a strong assist from federal, state and local governments, great strides have been made in the development of a variety of community programs specifically tooled to meet the individual needs of the mentally retarded, but only on a day care basis. Again, the options were few: remain with the natural parents with services provided by day care centers, or be sent to a state institution.

More recently a concept of "normalcy" has been developing in the minds and actions of some of the more futuristic and ingenious advocates of the mentally retarded, both lay and professional. This concept is nothing more than what all of us want and expect as part of our life style, what the fortunate in society take for granted: a house to live in, hopefully with a family; a school to attend when young; a job to perform to become an economic contributor to society; recreation with family and friends. Are the mentally retarded so different that they should not expect this as a basic human right? Many think not.

After two years of concentrated study, Indiana now has a plan for meeting the total needs of the mentally retarded for both service and residential living. This plan proposes to bring the state hospital and community closer together and to offer several options

which include the natural home, foster home, small group home and the state hospital. Each will serve the specific needs of the retarded, at a time in his life when special help is required. Eventually, the state hospitals will become highly specialized institutions which will serve only those individuals with special needs, and in a residential environment conducive to normal living.

The planners, composed of deliverers of service, parents and voluntary advocates, have performed their task. The citizens of Indiana must now determine if this new day is to truly dawn with sunshine and hope.

Martin W. Meyer, Ed.D.
Project Director

ACKNOWLEDGEMENTS

The Steering Committee and project staff extend special recognition to several individuals and agencies who have voluntarily contributed much time and effort to the enhancement of this study.

Gerald Alpern, Ph.D., Director of Research, Child Psychiatry Services, Indiana University, and the staff of the Indiana University- Purdue University Research Computation Center substantially contributed to the development of the research instrument.

The progress of the legislative drafts to final passage and approval by the Governor was greatly due to the continuous support and promotion by Mr. Ronald J. Cutter, Assistant Director for Governmental and Inter-Agency Affairs, Indiana Association for Retarded Children.

Mr. Leo Dillon, Supervisor, Programs for the Mentally Retarded, Division of Special Education, Indiana Department of Public Instruction, assisted in the solicitation of cooperation from the various school districts in obtaining recent data.

Reverend Royce Jones, Executive Director, The Sycamores, prepared extensive materials to be incorporated in the development of licensing standards and sample budgets for residential facilities.

The success of the regional hearings was primarily due to the excellent organizational and promotional planning of the Executive Secretaries of the Mental Health- Mental Retardation Planning Commission.

Gratitude is also extended to Mr. Cless Sodtman and the staff of Fort Wayne State Hospital and Training Center for the printing, collating and binding of the interim and final project reports.

Miss Suzanne Turner
Associate Project Director

INDIANA
MENTAL HEALTH-MENTAL RETARDATION
PLANNING REGIONS

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CHAPTER I

PLANNING ORGANIZATION

I. INDIANA MENTAL HEALTH--MENTAL RETARDATION PLANNING COMMISSION

II. INDIANA ASSOCIATION FOR RETARDED CHILDREN

III. PROJECT ADMINISTRATION

CHAPTER I

PLANNING ORGANIZATION

I. INDIANA MENTAL HEALTH--MENTAL RETARDATION PLANNING COMMISSION

The Commission was established by Governor's decree in 1963 as the planning body for mental health and mental retardation as mandated by PL 88-164. Legislative action in 1967 intrusted the commission with the responsibility of serving the Governor, the Legislature and the Department of Mental Health as the agent for continuous state-wide planning and for such special studies into the many activities of the Department, as may be requested by the Governor, the Legislature, legislative study committee, or the Department.

Chairman:	Mr. Thomas Binford Indianapolis, Indiana
Executive Director:	Martin Meyer, Ed.D., Director Division of Planning & Evaluation Indiana Department of Mental Health Indianapolis, Indiana
Ex-Officio Member:	William E. Murray, M.D., Commissioner Indiana Department of Mental Health Indianapolis, Indiana

REGIONAL PLANNING COMMITTEES

Calumet Region (1)

Chairman:	Mr. Russell Keller Crown Point, Indiana
Co-Chairman:	Herman Feldman, Ph.D. Indiana University, Northwest Campus Gary, Indiana
Executive Secretary:	Mr. Joseph J. Culberg Highland, Indiana

South Bend-Elkhart Region (2)

Co-Chairman:	Honorable Jesse L. Dickinson South Bend, Indiana
Executive Secretary:	Mr. Robert Pollitt Mishawaka, Indiana

Northeastern Region (3)

Chairman:	Mr. Lawrence J. Castaldi Warsaw, Indiana
Executive Secretary:	Mr. Ronald Custance Fort Wayne, Indiana

Lafayette Region (4)

Chairman:	Vacant
Executive Secretary:	Vacant

North Central Indiana Region (5)

Chairman:	Vacant
Executive Secretary:	Vacant

Muncie Region (6)

Chairman:	Vacant
Executive Secretary:	Vacant

Terre Haute Region (7)

Chairman:	Jacob Cobb, Ph.D. Indiana State University Terre Haute, Indiana
Co-Chairman:	Mr. James F. Conover Terre Haute, Indiana
Executive Secretary:	Mrs. E. R. Pettebone Terre Haute, Indiana

Central Region (8)

Chairman:	Honorable Harold W. Handley Indianapolis, Indiana
Executive Secretary:	Mrs. Genevieve Riley Indianapolis, Indiana

Richmond Region (9)

Chairman:	Vacant
Executive Secretary:	Vacant

Bloomington Region (10)

Chairman:	Vacant
Executive Secretary:	Vacant

South Central Region (11)

Chairman:	Mr. Lowell Engelking Columbus, Indiana
Executive Secretary:	Mrs. Juanita Stofer Columbus, Indiana

Cincinnati Region (12)

Chairman:	Mr. James H. Noyes Lawrenceburg, Indiana
Executive Secretary:	Mrs. Kathryn Jenkins Lawrenceburg, Indiana

Southwestern Region (13)

Chairman:	Mr. Bernald Schnacke Evansville, Indiana
Executive Secretary:	Mr. Douglas Williams Evansville, Indiana

Southwestern Region (13A)

Chairman:	Judge Phillip D. Walker Washington, Indiana

Southeastern Region (14)

Chairman:	Mr. J. E. Miller Sellersburg, Indiana
Executive Secretary:	Mrs. El Jean Faigle Jeffersonville, Indiana

VOLUNTARY COMMUNITY AGENCIES

Mental Health Association in Indiana	Mr. Walter J. Matthews Plainfield, Indiana
Indiana Association for Retarded Children, Inc.	Mr. Edward A. Otting Indianapolis, Indiana
Association for Out-Patients Clinics	Harold J. Nichols, M. D. Mental Health Center of St. Joseph County South Bend, Indiana
Conference of Executives of Association for the Mentally Retarded	Mr. Howard Wilson Warsaw, Indiana
Representation from Community Mental Health Centers	Vacant

INDIANA DEPARTMENT OF MENTAL HEALTH

Mental Illness:	John U. Keating, M.D., Superintendent Central State Hospital Indianapolis, Indiana
Mental Retardation:	Ora R. Ackerman, Ed.D., Superintendent Fort Wayne State Hospital and Training Center Fort Wayne, Indiana
Neurological Services:	Vacant
Children's Services:	C. Raymond Kiefer, M.D., Director Indiana Department of Mental Health Indianapolis, Indiana
Education and Training:	Donald F. Moore, M. D. Larue Carter Memorial Hospital Indianapolis, Indiana

II. INDIANA ASSOCIATION FOR RETARDED CHILDREN

So that the project could operate more readily, this association volunteered to serve as the fiscal agent for the project.

President:	Jack Gruenenfelder, Ph.D. Indiana University, Northwest Campus Gary, Indiana
Executive Director	Mr. Frank E. Ball Indianapolis, Indiana

III. PROJECT ADMINISTRATION

A.PERSONNEL

The Director of the Division of Planning and Evaluation, Indiana Department of Mental Health, Martin Meyer, Ed.D., serves as the Project Director.

In September, 1970, Miss Suzanne Turner was employed as Associate Project Director, and in June, 1971, Mrs. Linda Foster assumed the duties of Assistant Project Director.

B.STEERING COMMITTEE

The Steering Committee members were appointed by the chairman of the Indiana Mental Health-Mental Retardation Planning Commission and represent expertise in the various areas of interest and concern for the mentally retarded. Several of the participants are also parents of retarded children. This committee was empowered by the Commission to make policy decisions regarding the activities of the planning project; thus monthly meetings were held for this purpose.

STEERING COMMITTEE

Co-Chairman:	Martin Meyer, Ed.D., Executive Director Indiana Mental Health-Mental Retardation Planning Commission Indianapolis, Indiana
Co-Chairman:	Mr. Frank E. Ball, Executive Director Indiana Association for Retarded Children Indianapolis, Indiana

MEMBERS

Ora R. Ackerman,Ed.D.	Superintendent Fort Wayne State Hospital and Training Center Fort Wayne, Indiana

Mrs. Shirley Amond	Director Special Education and Joint Services Program New Whiteland, Indiana
Mr. James T. Austin	Executive Director Allen County Association for the Retarded, Inc. Fort Wayne, Indiana
Jacob Cobb, Ph.D.	Dean of Graduate Studies Indiana State University Terre Haute, Indiana
Mrs. Kathy Curtis	Mt. Vernon, Indiana
Walter E. Deacon, M.D., M.P.H.	Medical Director Services for Crippled Children Indiana Department of Public Welfare Indianapolis, Indiana
Mr. David J. Field	Chief of Design and Development John Curry and Associates Terre Haute, Indiana
Mrs. Margaret Ferguson	Services for Crippled Children Indiana Department of Public Welfare Indianapolis, Indiana
Mrs. Kathryn Jenkins	Executive Secretary Regional Mental Health--Mental Retardation Planning Committee Lawrenceburg, Indiana
Mr. Edward A. Otting	Immediate Past President Indiana Association for Retarded Children Indianapolis, Indiana
Martin Ridge, Ph.D.	Department of History Indiana University Bloomington, Indiana
Mrs. Bette Rubinstein	Title I - 89-313 Regional Consultant Lafayette, Indiana
Mr. Frank Ryan	Executive Director Marion County Association for Retarded Children Indianapolis, Indiana

Mr. G. Linden Thorn	Executive Director Council for the Retarded of St. Joseph County South Bend, Indiana

PROJECT CONSULTANTS

Raymond Dembinski, Ed.D.	Administrative Director Developmental Disabilities Program Indianapolis, Indiana
Mr. Robert Spaulding	Director Division of Mental Retardation Indiana Department of Mental Health Indianapolis, Indiana

SPECIAL CONSULTANTS

C. Raymond Kiefer, M.D.	Director Division of Child Mental Health Indiana Department of Mental Health Indianapolis, Indiana
Mr. R.L. Reichard	Consultant Psychiatric Social Work Indiana Department of Mental Health Indianapolis, Indiana
Miss Dorris O. Stewart	Director Psychiatric Nursing Indiana Department of Mental Health Indianapolis, Indiana

C. SPECIAL STUDY COMMITTEES

To provide a more thorough study and possible recommendations regarding Family Care, licensing of facilities, and costs of facility operations, three special study committees were appointed.

1. FAMILY CARE COMMITTEE

Dorothy Lindegren, Chairman	Fort Wayne State Hospital and Training Center
Jacqueline Berns	Marion County Association for Retarded Children
Wilbur Rodenberg	Wayne County Association for Retarded Children

Bette Rubinstein	PL 89-313
Dorris Stewart	Indiana Department of Mental Health
Linden Thorn	Council for the Retarded of St. Joseph County
Ione Trapp	Muscatatuck State Hospital and Training Center
Richard Akers, Ex-Officio	Indiana State Board of Accounts

2. LICENSING COMMITTEE

Frank Ryan, Chairman	Marion County Association for Retarded Children
R. L. Reichard	Indiana Department of Mental Health
Robert Spaulding	Indiana Department of Mental Health
Dorris Stewart	Indiana Department of Mental Health

3. RESIDENTIAL FACILITY COSTS COMMITTEE

Ora Ackerman, Ed.D., Chairman	Superintendent Fort Wayne State Hospital and Training Center
Charles J. Seevers, Ph.D.	Executive Director Elkhart County Association for Retarded Children
Reverend Royce Jones	Executive Director Sycamores

CHAPTER II

INTRODUCTION

I. ESTABLISHMENT OF PROJECT

II. PROGRAM PLAN

CHAPTER II

INTRODUCTION

I. ESTABLISHMENT OF PROJECT

Planning in the 1960's for the mentally retarded was focused primarily on the development of community services and the extension of public school educational services. The State Plan for the Mentally Retarded which was completed in 1964 under the aegis of the Mental Health-Mental Retardation Planning Commission delineated through the planning regions of the State in great detail the numbers of persons to be served and the types of services to be developed. Even though the report was quite complete, there was a glaring omission in planning for a wide range of residential services to complement the aforementioned community services.

As late as 1969 the only viable residential alternatives to home care for the mentally retarded individual were institutional or foster care placement. Tremendous strides in the late 1960's were made in securing legislation and funds for the support of community services, and the major portion of the activities performed by the local associations for retarded children was likewise focused on the community services. In fact, Indiana has the distinction of being one of the foremost states in the array of community services available to the mentally retarded. If the State could develop the residential components to match the community services, Indiana would be far in advance of other states in this regard. It was obvious that the trend toward keeping the retarded person in the community to take advantage of local services would ultimately be frustrated if there were not residential components to care for the retarded when the family and/or natural home was no longer feasible. Parents, administrators, and professionals at all levels were frustrated in their efforts to improve conditions at the state institutions.

In the late 1960's, several other states had begun to institute radical,sweeping changes in their residential care of the mentally retarded. News of new models of treatment and residential facilities in the European countries was being discussed and the President's Committee on Mental Retardation had just published a landmark document, Changing Patterns in Residential Services featuring the concept of normalization.

Being desirous of providing a most complete system of services, the Mental Health-Mental Retardation Planning Commission recognized the need for further study of residential care in Indiana.

The Commission, therefore, applied for and received a grant from the Indiana State Board of Health for the purpose of developing a plan which would delineate the types of residential facilities needed within a community or service area which will keep the individual in his home community and enhance his habilitation through local treatment, educational and vocational pursuits.

II. PROGRAM PLAN

The prospect of collecting a vast array of information necessitated the development of a program plan for this project. A program plan often referred to as "Management by Objectives" consists of four elements: (a) identifying problems, (b) planning to overcome problems by use of quantified objectives, (c) devising a plan of action to overcome and reach objectives and (d) periodic evaluation to delineate how much progress has been made within a given period of time. These four elements are encompassed by a goal which is a generalized statement as to what purpose is desired.

This process was incorporated in the development of the Project Program Plan (Appendix A). An evaluation within the last six months measured the progress of the plan. It will be noted in reviewing (Appendix A) the Program Plan, that the problems have been overcome and the goal attained. The development of this plan does not imply that all of the problems leading to the implementation of the plan have been resolved. Legislative action and revision of existing state regulatory controls (licensing, fiscal accountability, etc.) are needed to implement the goal and philosophy of this project.

CHAPTER III

PHILOSOPHY

I. NEED FOR PHILOSOPHY

II. STATEMENT OF PHILOSOPHY

CHAPTER III

PHILOSOPHY

I. NEED FOR PHILOSOPHY

The Indiana Mental Retardation Residential Services Planning Project Steering Committee believed that it was necessary to develop a philosophy that would serve as a major focal point in the determination of needs and development of a plan to meet specific needs of the retarded throughout the State of Indiana.

The attitudes of both the Division of Mental Retardation, Indiana Department of Mental Health and the Indiana Association for Retarded Children were incorporated in the philosophy developed by the Steering Committee. The Committee also contends that that the following statement of philosophy should be adopted by all groups in the state- public and private- that are planning or developing residential facilities so that a degree of uniformity will exist in the planning and administration of programs.

II. STATEMENT OF PHILOSOPHY

Residential services encompass not only the residential living services but also the provision of appropriate services which are complementary to the individual's needs and which make it possible for the individual to take advantage of the community residential service facilities. Such services are to be provided for every individual within the State who needs them. These services are essential to enable each individual to reach the full development and realization of his potential regardless of his ability or disability, status, or derivation.

The initial and primary resource in the care of the retarded is the home and family. It is essential that the natural home and the residential service facilities have full access to the entire spectrum of ancillary services which are complementary to the maximum development of the individual. Every effort will be made to assist the family in providing this care. If the natural home setting is not appropriate for the maximum development of the individual, then the state must accept the responsibility for obtaining the needed services.

Residential services and necessary complementary supportive services should be available to an individual in or near his own community and the individual must be considered an integral part of the community and not as a separate or independent factor. Moreover, residential services should encompass the basic characteristics of the natural home in terms of numbers of members present, furnishings, social and other human interrelationships

with the realization that complementary adjustments may be necessary to assist the individual to obtain his maximum development depending upon his needs, age, and level of development. There should be free movement from one residential service to another as each individual's needs change for age or other reasons including emancipation.

Daily living and appropriate training includes risks, even for the retarded. A regulated and controlled environment satisfies the need for protection but ignores the needs to attain gainful, knowledgeable, satisfying and self-respecting lives.

CHAPTER IV

RESIDENTIAL MODELS

I. NATURAL HOME

II. ALTERNATIVES TO NATURAL HOMES

III. LARGER RESIDENTIAL FACILITIES

IV. STATE SPECIAL SERVICE FACILITIES

V. PRIVATE RESIDENTIAL FACILITY STUDY

CHAPTER IV

RESIDENTIAL MODELS

I. THE NATURAL HOME (All Ages)

As related in the philosophy, the initial and primary resource in the care of the retarded is the home and family. Every effort will be made to provide the generic and specialized services to each family unit which will enhance the capabilities of the retarded individual.

Appropriate auxilliary community service systems, if properly developed within the state, should allow the majority of the retarded citizens the opportunity to develop normally within their natural home, or within the community upon emancipation from the home.

II. ALTERNATIVES TO THE NATURAL HOME (All Ages)

A. Foster Home

A foster home is defined as a family home which provides child rearing functions in lieu of the individual's natural parents. These families usually would have no more than two retarded persons placed as members of the total family unit. Presently both local Departments of Public Welfare and the Family Care program in the Department of Mental Health support this type of home setting.

B. Small Group Homes

The small group home is a facility supervised by adults and housing no more than six to twelve residents.

The alternative "models" cited below are listed by age group and primary residence function. Each community must have the ability to alter appropriately the various models in order to best serve the needs of local retarded citizens. The models listed are being recommended on the basis of needs of the retarded as indicated in the recent project survey. It is recognized, however, that new or modified models may be developed as individuals' programming needs vary. These homes may be owned and/or operated by public or private profit or non-profit corporations.

1. Developmental or Infant Homes - (Ages 0 - 5+) - residents will be enrolled in a community service for diagnosis of degree of retardation; development of motor, communicative and motivational skills. Consideration of ages, abilities and limitations should be made only as to how it may be most manageable for the house parents and other children involved. Ages of residents may also depend upon the progress of the child; physically, mentally and emotionally.

2. Educational Homes - (Ages 5 - 13) - minimal day-time supervision will be needed since these children will be participating in community programs for the educable, trainable and higher functioning sub-trainable. Age and intellectual abilities should play a minor role in placement, since a normal home does not have children all the same age and functioning level.

3. Pre-Vocational Training Homes - (Ages 13+ - 16) - residents will be teen-agers who are enrolled in special education programs, workshops, etc. Emphasis to be placed on employment feasibility, exploration of various skills and trades, and social adjustment.

4. Correctional Homes - (Ages 13+) - a more structured and well supervised unit is needed for those mentally retarded who have potential for delinquent behavior. These individuals will be enrolled in programs similar to those in the other units.

5. Vocational Training and Employment - (Ages 16+) - residents will be seeking further training or employment in the community. Supervision and assistance will be provided at home in cooking, purchasing of food and clothing, and other domestic skills. Eventually these residents will be living alone or with very minimal supervision.

6. Semi-Independent Living - (Ages 18+) - residential arrangements will permit the individuals to be free of close supervision, and possess ultimate responsibilities of daily living. Due to unconceived emergencies, etc., someone should be responsible for periodic checking of the residence and with the residents. The ideal program preferred by young people is that of apartment living. Residents will be employed in the community or sheltered workshop.

7. Self-Esteem Homes -(All Ages) - there will be those individuals of various ages who will have reached their potential at an early age, and the functioning will be quite minimal. This condition still requires care, concern and preservation of dignity. These individuals will not require medical care.

Assistance is often needed in times of illness, death, vacations, etc., necessitating local crisis or respite care facilities. Due to such factors as the unpredictability of numbers needing the service, length of stay, etc., it is recommended that some vacancies be maintained in the various types of residential models rather than develop a facility exclusively for crisis or respite care.

III. LARGER RESIDENTIAL FACILITIES

Some retarded citizens will be so severely physically impaired so as to require continuous nursing and/or medical care. Other

individuals may no longer be able to work; however, they may still require only minimal supervision. Individuals in either of these two categories may be appropriately placed in nursing homes for children and/or adults.

A larger residential facility is any building or complex which houses more than twelve residents. This facility would offer a specialized service program and would be manned usually by a highly trained staff. Ownership and/or operation could be similar to the aforementioned facilities.

IV. STATE OPERATED SPECIAL SERVICE FACILITIES (All Ages)

The State of Indiana should provide specialized services to communities within separate state operated facilities. The provision of comprehensive services should supplement the direct and/or indirect delivery systems being designed in each of the fourteen mental health-mental retardation planning regions. Each case should be considered based upon the individual needs and resources available within each community.

State facilities should no longer be the primary providers of residential living with limited ancillary services for retarded citizens. Residential services should be increasingly developed within the regions and communities. The state facility should provide those specialized, short-term, intensive services which cannot be duplicated within each community or region. Residential services in state facilities should be ancillary to the major specialized service programs.

It is anticipated that these specialized services will be provided to:

1. Delinquents.
2. The hyperactive.
3. Vocational rehabilitatives.
4. Medically undiagnosed.
5. The special medical and multi-handicapped.

Each of the retarded citizens placed in any of the alternative residential models described in this chapter must be guaranteed a comprehensive developmental program which meets his needs and abilities. Such programming should, whenever possible, be offered outside the residential service facility.

V. PRIVATE RESIDENTIAL FACILITY STUDY

The Steering Committee felt the importance of reviewing the programming available to the mentally retarded in the existing private residential facilities in the state and discussing with administrators the advantages and obstacles in the operations.

Private residential facilities which care for the retarded and are licensed by the Indiana State Board of Health, or are serving a higher functioning retarded population and are not licensed by a state agency were included in the study. A mentally retarded population of 519 was identified in sixteen facilities.

The survey results are indicated on the accompanying chart. There appears to be no significant difference in quality of service between the proprietary and not-for-profit facilities.

It is recognized by the Steering Committee that private facilities will continue to be developed as an important source of residential services. Therefore, it is recommended that adequate and realistic licensing codes be initiated, taking into consideration the need of the mentally retarded for normal "risk-taking" in their daily living. It is further recommended that standards be developed for ancillary programs within either the facility or other community resources so that the availability of adequate programs is insured. Priority for state reimbursement should be given to those facilities who meet the various recommendations in this plan, regardless of the proprietary status.

PRIVATE RESIDENTIAL FACILITIES

Private Residential Facilities(16)	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	Total
Licensed ISBH	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	N/A	Yes	N/A	Yes	Yes	Yes	N/A	
Total Capacity	65	44	8	16	34	17	83	152	16	16	211	10	199	133	24	20	
Present Census	65	39	2	6	34	17	77	175	16	14	167	10	135	130	12	20	919
M/R Population	15	39	2	6	34	17	77	48	16	14	59	10	20	130	12	20	519
M/R Vacancies	0	5	6	10	0	0	6	0	0	2	22	0	17	3	12	0	83
Separate Units for M/R	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A	Yes	N/A	N/A	N/A	
M/R Pop. under 5 yrs. age	0	0	0	2	10	12	0	11	3	0	15	1	1	45	0	0	100
M/R Pop. 5-16 yrs. age	0	0	2	4	24	5	19	13	13	0	41	5	11	85	0	18	240
M/R Pop. 17-35 yrs. age	1	11	0	0	0	0	0	3	0	13	3	3	4	0	2	2	42
M/R Pop. 36+ age	14	28	0	0	0	0	58	21	0	1	0	1	4	0	10	0	137
M/R's prev. institutionalized	15	10	0	0	0	0	19	29	7	7	19	2	17	33	12	0	170
Primary $ Resource-Fam.Care	12	20	0	0	0	0	0	4	7	2	19	0	10	33	12	0	119
Primary $ Resource-DPW	3	3	1	6	28	17	47	42	7.5	5	38	3	8	70	0	20	298.5
Primary $ Resource-Soc.Sec.	0	16	0	0	0	0	0	0	0	1	0	0	0	0	0	0	17
Primary $ Resource-Family	0	0	1	0	6	0	30	2	1.5	6	1	7	0	3	0	0	57.5
Primary $ Resource-Other	0	0	0	0	0	0	0	0	0	0	1	0	**2	*24	0	0	27
Avg. cost per mo.(30 days)	200	51	270	450	375	375	375	540	390	270	540	138	540	360	135	330	
Cost includes clothing	No	No	Yes	No	No	Yes	No	No	Yes	No	No	No	No	No	No	Yes	
Cost includes medication	No	No	Yes	No	No	Yes	Yes	No	Yes	No	No	No	No	No	No	Yes	
Prog. Dir.-Not Admin.	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	
Licensed Teacher	0	0	0	0	0	0	0	pt-1	pt-1	0	0	0	0	0	0	0	
Unlicensed Teacher	0	0	0	0	0	0	0	pt-1	0	0	0	0	pt-1	0	0	0	
*Registered Nurses	2	0	0	0	0	0	6	4	0	0	2-1	0	3	2	0	0	
Social Caseworker	0	0	0	0	0	0	0	pt-1	0	0	0	pt-2	pt-1	0	0	0	
Physical Therapist	0	0	0	0	0	0	0	*1	0	0	*1	0	*1	0	0	0	
Speech Therapist	0	0	0	0	0	0	0	*1	0	0	*1	0	pt*1	0	0	0	
Occupational/Recr. Therp.	0	0	0	0	0	0	pt-1	1	0	0	0	0	1	0	0	0	

*Therapy administered at additional cost
*R.N. assigned to M/R
N/A used for "separate units for M/R" if facility serves only the retarded
Information provided by facility administrators
pt means part-time
**Illinois Department of Mental Health

CHAPTER V

PERSONAL INVENTORY

I. ESTABLISHMENT AND ADMINISTRATION OF INVENTORY

II. INVENTORY RESULTS

CHAPTER V

PERSONAL INVENTORY

I. ESTABLISHMENT AND ADMINISTRATION OF INVENTORY

Before the Project could begin to prepare a plan for residential services, it was essential to secure an accurate demographic analysis of the retarded population of the state who will require continued supervised living. This was necessary because no single state or private agency had developed accurate or current totals and only crude projections of the mentally retarded population existed.

The Personal Inventory (Appendix B) was developed by the staff with research consultation. Services of the Indiana University-Purdue University Research Computation Center were contracted for the computerization of all data. The survey was conducted in all state correctional and mental health facilities, community rehabilitation centers, public schools, and nursing facilities throughout the state. The survey was administered during a sixteen month period (December, 1970 - April, 1972). To assure uniformity in completion of the surveys, the project staff either directly reviewed case records and recorded information or worked closely with facility personnel who completed the surveys.

II. INVENTORY RESULTS

There were 15,308 mentally retarded persons identified who will require some type of supervised residential care throughout the remainder of their lives. The total population of the three mental retardation hospitals is considered in the survey (4,336).

It is estimated that approximately 17% of the total populaton at Beatty, Central, Evansville, Logansport, New Castle, Madison, and Richmond is retarded and will require continued supervised living (at the time of the survey, there were no retarded individuals residing at LaRue Carter or Evansville Children's Psychiatric Center). In the greater portion of these cases, mental retardation is a secondary diagnosis.

Specific programming for the mentally retarded public offender is substantiated by data from both the mental health and correctional facilities. In the correctional facilities, approximately 665 individuals test below I. Q. 83. Those appearing to be in need of supervised care number 140. Histories and progress reports of 178 mentally retarded individuals residing at mental health facilities indicate involvement with the police and/or courts.

An additional 299 retarded delinquents are enrolled in community programs for the retarded.

There are only eight nursing facilities in the state exclusively serving the retarded. Presently, approximately 230 individuals reside in these facilities. An additional 111 retarded have been identified in licensed public and private nursing homes.

The tables that follow disclose total numbers of the retarded by age in the state who will continue to need supervised living as actually identified; total number of facilities as projected and estimates of individuals requiring nursing services; and a break down of these figures by region. The regional figures indicate distribution according to residence either in the natural home or outside of the home, as well as distribution by age. The per centages are rounded to the nearest per cent. The variety of small group homes described in Chapter IV represent the number projected on the basis of the survey data.

STATE TOTALS *

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	958	6%
7 - 12	3922	26%
13 - 17	3192	21%
18 - 25	2766	18%
26 - 50	3021	20%
51 - 65	1052	7%
66+	397	3%
	15,308	100%

(6,052 of these individuals are currently enrolled in one of the ten Mental Health institutions. This does not include LaRue Carter or Evansville Psychiatric Children's Center)

* The individuals identified were only those who would require supervision throughout their lifetime.

PROJECTED STATE TOTALS OF REQUIRED FACILITIES

(Six to Eight Individuals Per Home)

Developmental	119 Homes
Educational	405 Homes
Pre-Vocational	319 Homes
Correctional	66 Homes
Vocational	377 Homes
Semi-Independent	134 Homes
Self Esteem	459 Homes
	1,879 Homes *

Needing Medical Placement — Approximately 2,062 Individuals

* This number is based on the entire identified population including those who are presently and may in the future reside in their natural homes. Hopefully, with the enhancement of community programs, the retarded individual will be able to remain in the natural home indefinately, thus reducing the number of homes actually required in the future.

REGION 1 (Lake, Porter, LaPorte, Newton, Jasper, Starke, Pulaski, Counties)

Total - 2,148

Natural Home - 1,128

Out of Home - 1,020

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	144	7%
7 - 12	527	25%
13 - 17	411	19%
18 - 25	476	22%
26 - 50	414	19%
51 - 65	137	6%
66+	39	2%
	2,148	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	20 Homes
Educational	76 Homes
Pre-Vocational	30 Homes
Correctional	11 Homes
Vocational	74 Homes
Semi-Independent	18 Homes
Self Esteem	60 Homes

Needing Medical Placement Approximately 240 Individuals

REGION 2 (Saint Joseph, Elkhart, Marshall, Kosciusko, Counties)

Total - 1,256 (Unable to obtain information from School City of Mishawaka)

Natural Home - 624

Out of Home - 632

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	106	8%
7 - 12	262	21%
13 - 17	237	19%
18 - 25	254	20%
26 - 50	289	23%
51 - 65	88	7%
66+	20	2%
	1,256	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	17 Homes
Educational	30 Homes
Pre-Vocational	23 Homes
Correctional	8 Homes
Vocational	34 Homes
Semi-Independent	8 Homes
Self Esteem	43 Homes

Needing Medical Placement Approximately 138 Individuals

REGION 3 (LaGrange, Steuben, Noble, DeKalb, Huntington, Wells, Adams, Allen, Whitley, Counties)

Total - 1,527

Natural Home - 875

Out of Home - 652

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	81	5%
7 - 12	370	24%
13 - 17	369	24%
18 - 25	299	20%
26 - 50	297	19%
51 - 65	81	5%
66+	30	2%
	1,527	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	11 Homes
Educational	57 Homes
Pre-Vocational	37 Homes
Correctional	12 Homes
Vocational	49 Homes
Semi-Independent	17 Homes
Self Esteem	32 Homes

Needing Medical Placement Approximately 140 Individuals

REGION 4 (Newton, White, Carroll, Warren, Tippecanoe, Fountain, Montgomery, Clinton, Counties)

Total - 924

Natural Home - 534

Out of Home - 390

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	95	10%
7 - 12	237	26%
13 - 17	148	16%
18 - 25	162	18%
26 - 50	184	20%
51 - 65	66	7%
66+	32	3%
	924	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	14 Homes
Educational	30 Homes
Pre-Vocational	14 Homes
Correctional	2 Homes
Vocational	30 Homes
Semi-Independent	7 Homes
Self Esteem	29 Homes

Needing Medical Placement Approximately 99 Individuals

REGION 5 (Fulton, Cass, Miami, Wabash, Howard, Tipton Counties)

Total - 761

Natural Home - 383

Out of Home - 378

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	72	9%
7 - 12	191	25%
13 - 17	157	21%
18 - 25	128	17%
26 - 50	134	18%
51 - 65	56	7%
66+	23	3%
	761	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	5 Homes
Educational	25 Homes
Pre-Vocational	14 Homes
Correctional	3 Homes
Vocational	16 Homes
Semi-Independent	7 Homes
Self Esteem	21 Homes

Needing Medical Placement — Approximately 163 Individuals

REGION 6 (Grant, Blackford, Jay, Madison, Delaware, Randolph, Henry Counties)

Total - 1,193 (Unable to obtain information from Marion Community Schools)

Natural Home - 511

Out of Home - 682

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED.
1 - 6	48	4%
7 - 12	263	22%
13 - 17	222	19%
18 - 25	236	20%
26 - 50	273	23%
51 - 65	109	9%
66+	42	4%
	1,193	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	5 Homes
Educational	39 Homes
Pre-Vocational	10 Homes
Correctional	5 Homes
Vocational	30 Homes
Semi-Independent	15 Homes
Self Esteem	44 Homes

Needing Medical Placement — Approximately 192 Individuals

REGION 7 (Vermillion, Parke, Putnam, Vigo, Clay, Sullivan Counties)

Total - 575

Natural Home - 291

Out of Home - 284

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	21	4%
7 - 12	100	17%
13 - 17	98	17%
18 - 25	100	17%
26 - 50	150	26%
51 - 65	74	13%
66+	32	6%
	575	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	4 Homes
Educational	11 Homes
Pre-Vocational	10 Homes
Correctional	2 Homes
Vocational	9 Homes
Semi-Independent	7 Homes
Self Esteem	8 Homes

Needing Medical Placement — Approximately 113 Individuals

REGION 8 (Boone, Hamilton, Hendricks, Marion, Hancock, Morgan, Johnson, Shelby)

Total - 3,313

Natural Home - 1,913

Out of Home - 1,400

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	202	6%
7 - 12	1,060	32%
13 - 17	805	24%
18 - 25	509	15%
26 - 50	513	15%
51 - 65	161	5%
66+	63	2%
	3,313	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	24 Homes
Educational	35 Homes
Pre-Vocational	110 Homes
Correctional	14 Homes
Vocational	55 Homes
Semi-Independent	17 Homes
Self Esteem	114 Homes

Needing Medical Placement Approximately 402 Individuals

REGION 9 (Rush, Wayne, Fayette, Union, Franklin, Counties)

Total - 496

Natural Home - 276

Out of Home - 220

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	16	3%
7 - 12	156	31%
13 - 17	103	21%
18 - 25	91	18%
26 - 50	90	18%
51 - 65	28	6%
66+	12	2%
	496	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	1 Home
Educational	20 Homes
Pre-Vocational	9 Homes
Correctional	1 Home
Vocational	9 Homes
Semi-Independent	4 Homes
Self Esteem	17 Homes

Needing Medical Placement — Approximately 74 Individuals

REGION 10 (Owen, Greene, Monroe, Lawrence, Counties)

Total - 357

Natural Home - 161

Out of Home - 196

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	16	4%
7 - 12	56	16%
13 - 17	82	23%
18 - 25	53	15%
26 - 50	105	29%
51 - 65	32	9%
66+	13	4%
	357	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	2 Homes
Educational	8 Homes
Pre-Vocational	5 Homes
Correctional	1 Home
Vocational	7 Homes
Semi-Independent	6 Homes
Self Esteem	12 Homes

Needing Medical Placement — Approximately 63 Individuals

REGION 11 (Brown, Bartholomew, Decatur, Jackson, Jennings, Counties)

Total - 436

Natural Home - 215

Out of Home - 221

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	20	5%
7 - 12	96	22%
13 - 17	106	24%
18 - 25	57	13%
26 - 50	89	20%
51 - 65	53	12%
66+	15	3%
	436	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	2 Homes
Educational	9 Homes
Pre-Vocational	14 Homes
Correctional	1 Home
Vocational	7 Homes
Semi-Independent	5 Homes
Self Esteem	10 Homes

Needing Medical Placement Approximately 82 Individuals

REGION 12 (Ripley, Dearborn, Jefferson, Ohio, Switzerland, Counties)

Total - 322

Natural Home - 173

Out of Home - 149

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	9	2%
7 - 12	84	26%
13 - 17	82	25%
18 - 25	52	16%
26 - 50	57	18%
51 - 65	22	7%
66+	16	5%
	322	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	1 Home
Educational	11 Homes
Pre-Vocational	8 Homes
Correctional	1 Home
Vocational	6 Homes
Semi-Independent	6 Homes
Self Esteem	6 Homes

Needing Medical Placement — Approximately 52 Individuals

REGION 13 (Knox, Daviess, Martin, Gibson, Pike, Dubois, Posey, Vanderburgh, Warrick, Spencer, Perry, Counties)

Total - 1,180

Natural Home - 579

Out of Home - 601

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	67	6%
7 - 12	249	21%
13 - 17	212	18%
18 - 25	245	21%
26 - 50	272	23%
51 - 65	95	8%
66+	40	3%
	1,180	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	7 Homes
Educational	18 Homes
Pre-Vocational	17 Homes
Correctional	2 Homes
Vocational	33 Homes
Semi-Independent	11 Homes
Self Esteem	43 Homes

Needing Medical Placement — Approximately 215 Individuals

REGION 14 (Orange, Washington, Scott, Clark, Crawford, Harrison, Floyd, Counties)

Total - 820
Natural Home - 513
Out of Home - 307

AGE	NUMBER	PERCENTAGE OF THOSE IDENTIFIED
1 - 6	61	7%
7 - 12	271	33%
13 - 17	160	20%
18 - 25	104	13%
26 - 50	154	19%
51 - 65	50	6%
66+	20	2%
	820	100%

RESIDENTIAL FACILITIES (6 - 8 persons per home)

Type	Approximately
Developmental	6 Homes
Educational	36 Homes
Pre-Vocational	18 Homes
Correctional	3 Homes
Vocational	18 Homes
Semi-Independent	6 Homes
Self Esteem	20 Homes

Needing Medical Placement — Approximately 89 Individuals

CHAPTER VI

FAMILY CARE

I. INTRODUCTION TO FAMILY CARE PROGRAM

II. ESTABLISHMENT OF AD HOC COMMITTEE

III. ANALYSIS OF FAMILY CARE PROGRAM

A. Scope

B. Costs

C. Private Home Placements

D. Nursing Home Placements

E. Supplement - Public Welfare Assistance to the Mentally Retarded

F. General Comments

VI. RECOMMENDATIONS

CHAPTER VI

FAMILY CARE

I. INTRODUCTION TO THE FAMILY CARE PROGRAM

Family Care is legislatively and legally related to hospitalization..." any patient of a state owned and operated psychiatric hospital...may be placed in an approved boarding home...approved by the Department of Mental Health" (Family Care Manual, Indiana Department of Mental Health). Many people need residential services who would not come forth to apply for service if eligibility to state institutions had to be established. Such a criteria would be self-limiting and contrary to the idea of preventing the overuse and misuse of the state institution. Many parents seek services but have no intention of placing a retarded person outside of his home community.

The state institution, having a group of experts in one location, could function as a diagnostic and evaluation center, in conjunction and cooperation with community mental retardation centers, for the purpose of assessing total needs; educational, social, developmental and residential. The need for the specific types of residential facilities (also home supportive services) could then be established. The institution eventually will be recognized as the provider of one type of residential service.

A full range of residential services should encompass the "Family Care" program and eventually replace it. The future will demonstrate less of a need for residential care to be directly related to hospitalization. The state institution will operate as one residential facility and not as the facility for residential care. Family Care will have served a vital need in moving people from "total care" in a state institution to the community. Those living in a state institution will require this type of care and others will be diverted to appropriate residential facilities as needed.

II. ESTABLISHMENT OF AD HOC COMMITTEE

Since the survey on private residential facilities indicated that the Family Care program is the primary financial resource for many of the private facilities, it was deemed necessary to further analyze the Family Care program. An Ad Hoc Committee

was organized to review family care statistics, study the present structure of the program, disposition of cases, quality of care, and utilization of community services for family care patients.

III. ANALYSIS OF FAMILY CARE PROGRAM

A. Scope

The survey administered by the project reveals that of 6,052 mentally retarded individuals residing in one of the state mental health institutions, 555 were family care placements during the period July 21, 1970 - August 20, 1970 (Appendix C). Additional statistics have been developed on the total 1,312 mental health patients who were participating in the family care program during the aforementioned period. The statistics have been used in a state workshop on Family Care, and they have been suggestive of future survey and data collection activity. The data provided a profile of the Family Care program at a given point in time.

Further analysis would depend on the development of "profile charts" covering all patients and residents of Department of Mental Health programs. Current information suggests a growing number, or larger group, both percent and total number of "chronic" patients in Family Care. Becoming self-sufficient for some could mean jobs, which require training, supervision and placement efforts. (For some, jobs would need to be created.) Becoming self-sufficient for others would mean an income maintenance program. If the resident is not gainfully employed, someone must pay for his "independent living" - apartments, minimum supervision homes, etc.

B. Costs

The rates paid for family care placements range up to $200 per month. The rate paid is set by the social worker and the householder and is based on the expenses the client can be expected to incur in his daily activities. Age, physical condition, program needs, capacity to earn, and degree of supervision needed are factors that affect the amount paid the householder. A flat fee of $200 is paid for residential nursing homes and the rates paid for comprehensive nursing care is based on the rate paid in the same home by the Department of Public Welfare.

The present average monthly payment for each placement is $155. This is based on statewide expenditures and is not the average monthly cost of placement for the retarded. A review of placements from Fort Wayne State Hospital relate, the average

payment to householders for the year 1969-70 was $142. a month. These figures include payment for fifteen children placed at the rate of $12. a day in a nursing home and eight adults placed at $200. a month in a nursing home. The rest of the placements were made in private and group homes. Altogether 207 different individuals were in placement at some time during the year. The age range was from infancy to old age and the functioning levels of the residents ranged from borderline to profound.

There are "hidden costs" in the Family Care program. Services in addition to board, room, and supervision were provided by staff of the Fort Wayne State Hospital. This included the time needed to locate, study, license and orient family care householders by the social service department; the time spent by vocational counselors in finding job placements and orienting the employers; treatment services by psychologists, nurses, doctors, etc. Much clothing was supplied by the hospital. Some fees were paid for services by community physicians and hospitals.

Several questions involving the present program include: could Family Care be expanded effectively to meet the needs of all retardates needing residential services; what are the basic rights of adults who cannot be independent and children who cannot live at home; can Family Care payments be increased to cover more completely the whole scope of training and experimental services needed by the retardate; what are some of the barriers of the Family Care program to effective functioning?

C. Private Home Placements

The funds provided for "householder" are expected to cover board, room, appropriate supervision, and the opportunity to live in the household and enjoy the status of a member of the family. In most cases this also would mean the client is provided with laundry services for his personal clothing and linens. In many cases additional services are provided by the householders. In the 78 Fort Wayne cases of placement in private homes, and in many of the group homes, the householders have worked very closely with the mentally retarded individuals; teaching them to shop, manage money, bank and travel by public transportation. Some of the householders have driven miles daily to get their clients to their work, to school, to clinics at the hospital, etc. To say that the Family

Care payment is for board, room and supervision is a very trivial way of describing the beautiful experience in family living shared by the client and by the people who provide the home. It was due to a persistent foster mother that one young boy was finally admitted to the School for the Deaf; another mother managed to persuade the parochial school of the neighborhood to admit and tailor programs for her four little girls. How does one place a dollar value on these services?

D. Nursing Home Placements

The staffs of well-operated nursing homes have professional pride, and strongly believe in the importance of providing for the social, recreational, religious and physical needs of their patients. Many of the adults placed in nursing homes have made dramatic gains from the experience. In no commercial setting in Indiana has anything that compares to the poverty of the physical surroundings in the older cottages at the State Hospitals been observed. Elderly clients are often entranced when they see their new homes, with private or semi-private rooms, rugs, dresser, curtains, modern adequate plumbing, etc. Very few have expressed a desire to return to the hospital.

The following are some of the programs and policy characteristics that affect the functioning of the Family Care program.

1. To be paid for by Family Care funds, a client must be on the rolls of a state mental health institution. This means that all the services of the state hospital are theoretically available to the client. These services include medical, psychological, nursing, social, recreational and vocational training and placement. In some cases, patients return for regular medical care; in fact, rather specialized medical services. (For instance, the child for whom a series of surgical procedures are needed to enable her to walk more easily).

2. All of the clients must be seen by a hospital representative at least four times a year. Many clients and their householders are seen more than once a week. Because they need so much attention, it is not practical to place them very far from the institution. Larger field work staff who could live in any city where service is needed, or cooperative arrangements with already existing local agencies are possible solutions to this problem.

3. As long as clients remain on the rolls of the state hospital, the staff is responsible for continued care and planning. An annual staffing may reveal gaps in the program. The staff must learn how to relate needs of each client to the available local services and local services must develop to meet these needs.

4. Commitment to a state hospital results in a form of guardianship being established. The state Mental Health Department system prescribes certain procedures for establishment of trust accounts, and for responsible handling of patient owned funds. This offers a protection that is not possible in the community short of the appointment of a guardian. Responsibility for the person is also a part of the covenant that is made with those committed. Most guardians do not have the responsibility of "guardian of the person". This gap of local services probably calls for legislation as well as the development of new local responsibility.

5. Clothing for state hospital residents, in the institution and on family care, is provided in a cumbersome way that does not allow for the development of a sense of taste and style. If the client has no personal resources, all clothing must be secured through the hospital warehouse, and an unbelievable anonymity is the trademark of these garments. They are guaranteed not to fade and to endure. The hospitals are not permitted any money in their operating budgets to pay for clothing. What they must do is borrow from other accounts, order, issue the clothing and then try to collect the amount permitted by law from the auditor of the county from which the client was admitted. The theory is that the auditor can then collect, or try to, from the client's family.

6. Handling the various personal resources of clients is very complicated. Federal laws as well as state laws and state policies direct and restrict the use of funds.

a. Family care payments to householders may not be augmented by payments from public welfare, social security or the client's personal earnings. The committee recommends that this be changed.

b. Social security, personal earnings, public welfare funds, railroad pensions, veteran's beneficiary benefits may all be combined for whomever proves eligible. Under certain circumstances, patients outside the institution are eligible also for trustee assistance.

c. The Social Security law requires that $350. be kept in a trust fund for burial and/or future care away from the hospital. Social Security trust funds are intended for the personal necessities of the client,i.e., clothing, recreation, personal possessions and other incidentals.

d. If a client is funded under the Family Care program and he earns money, the staff is required to have his earnings sent to the institution and deposited in his trust account. In some instances, this regulation is waived, especially when receiving and handling his own money is deemed a valuable part of the client's experience. From the client's account, he receives expense money for transportation, recreation, clothing and other miscellaneous expenses. This is a weekly and very cumbersome ritual. Each account must be handled separately.

e. One of the most complex and difficult aspects of the program is that of keeping a current record of the daily census of patients in Family Care. This group of patients is far more mobile than any group within the institution.

7. The Family Care program generally is based on the proposition that the householder will live in the home with the client and that a homelike atmosphere will prevail. Only in the case of institutional placements such as nursing homes is this feature waived.

The Family Care program does not provide payments for a week-end staff, house rental and/or hiring of full or part-time house parents. As a result, residents return to the institution when the householder cannot arrange for a friend or relative to substitute during an emergency.

Overall, Family Care has not reduced institution populations. The program has been an effective way to enlarge the scope of care. Beds are not kept vacant at the institution when someone leaves on family care; those beds are filled by someone else. Thus, each family care placement has meant additional work and considerable inconvenience to the staff at the institution.

8. The availability of services and the personalities of the householder and the client are the compelling considerations for placement.

E. Supplement - Public Welfare Assistance to the Mentally Retarded

Since 1937, a series of acts have produced a complex group of assistance programs in Indiana that are administered by the County Department of Public Welfare. Some of these programs are supported entirely by local funds and some by matching state and federal funds. These programs are designed to help physically handicapped adults, mentally handicapped adults, the elderly and crippled children.

Retarded children and adults are not singled out specifically in any one of these programs. Retarded people may qualify for assistance, individually, under any of these categories of assistance.

Seventy-nine county departments responded to a questionnaire sent to them in May 1971, concerning the retarded individuals receiving benefits under the disability, crippled children and child welfare programs. The following table shows the response.

Retarded Individuals Receiving Welfare Assistance and Services

Child Welfare Cases	419
Crippled Children's Cases	94
Disability Grants to Retarded Adults in own home	880
Disability Grants to Retarded Adults in Nursing Homes	414

(State Welfare officials relate that the number being served is in excess of the number reported)

The questionnaire did not request the numbers of retarded individuals provided for by Aid to the Blind and Old Age Assistance grants, since these programs do not automatically classify recipients by mental functioning levels. Some retarded adults have qualified for assistance on the basis of age or blindness.

Problems Involved in Using Welfare Programs

1. Eligibility for a grant depends on proof of economic need. Middle class families are regarded as ineligible for services that would impoverish them if they paid entirely for the care privately.

2. Certain programs (crippled childrens' services and child welfare services) are financed entirely from county and federal funds. Seasonal policy charges in determining eligibility occur even in the more affluent counties as the funds diminish during the year. The poorer counties are quite limited in programs.

3. The public attitude toward welfare recipients causes families to feel disgraced if they apply for assistance. This varies greatly. Public welfare caseworkers often exercise great sympathy and ingenuity in assisting people in all of the necessary planning. The attitude exists and is sufficiently prevalent as to be a barrier to the applicant.

4. The maximum grant allowed to an adult not living in a nursing home is $80. a month which is quite minimal for meeting daily living expenses.

5. The retarded adult who is not competent to handle his own affairs must have a guardian who will sign the welfare application. The guardian can be the client's parent. In the absence of a parent, another person must be persuaded to become guardian. Legal fees for appointments cost around $200. Court costs are $20, but these can be waived. Welfare departments need public spirited citizens to take on this duty.

6. Families often object to the court action necessary when child welfare services are approved. The more sophisticated parents take it in stride as a technicality. To the more vulnerable, it causes them to feel they are losing their child.

7. Local prejudices cause discrimination in locally supported programs administrated by county officials; standards can be suggested but not enforced by the State Department of Public Welfare.

F. General Comments

The committee accepts the proposition that the program developed should be funded on as broad as possible tax base. It would like to see the program administered locally, or at least regionally. The idea of flexible resources, preferably purchased under the free enterprise system, as compared with a series of little governmentally owned and operated institutions is preferred. Naturally, it is recognized that standards of care and service must be defined by the governmental agencies appropriate to the service.

Concern was expressed over the confusion that now prevails when a client tries to deal with governmental units. Those who work in State Hospitals and Welfare Departments know the daily frustrations of clients who bounce between the two agencies while the agencies vainly try to resolve the question of who has primary responsibility for the family in its particular situation. Hospital commitments are often due to the county's lack of money and staff to obtain and support foster home services.

The committee thought an "age of majority" should be established that would free parents from involuntary continued financial responsibility for a disabled adult child.

An advocacy agency should be established for retarded adults. The agent should be an official of local government to whom retarded citizens can appeal for personal help, and who, also, is responsible for calling into play the protective restraints retarded adults sometimes need. The law presently provides for the restraint, but since no one agent in the community is specifically designated as the special friend of the retarded, the service is often not available as needed.

Neither of the present funding systems (welfare or family care) could adequately cover the costs of homes and training programs. Some of the Training Centers report that day care programs are now costing between $1,600 and $2,000 a year per participant. It would be pointless to try to compare costs of community and institutional programs. The State Hospital programs do not compare because of their highly selective case load, that often is much more problematic than the case load that will eventually be assumed by the residential centers.

Concern was expressed over the problems of residence. This pertained especially to the difficult financial position of the regional training center when a client not identified with that region enrolles for a program. State law provides for orderly transfer of funds from one public school district to another for children enrolled in public school. Perhaps a similar reciprocity could be designed for the training center services offered to out-of-county applicants.

As "residential services" develop and become a reality, Family Care as it now exists can be gradually phased out of existence. There will be less of a need to place people out from state institutions as institution population declines and as community programs diminish the need to place people in state institutions.

The question of continued Department of Mental Health responsibility for the maintenance support of dependent persons, who have been treated or rehabilitated, will need to be resolved.

Consideration should be given to the following issues:

Should the Department of Mental Health continue to support people, financially and otherwise, who are no longer receiving or in apparent need of Department of Mental Health services? Will other support systems such as the Department of Public Welfare and Social Security assume full responsibility? This may require legislation action and full state funding. The HR-1 proposal calls for a transfer of OAA and Aid to the Disabled to the federal social security system. The Department of Mental Health assumes this responsibility if the individual has been institutionalized. The individual equally in need gets limited help if he has never been in a state institution. Financial help for families with "special" needs might in the long run be cheaper, keep more families together, provide a better range of services, and assist more people in reaching a level of greater self-responsibility and self-fulfillment.

IV. RECOMMENDATIONS

A. Training and activity programs not available under public school auspices should be paid for by the Department of Mental Health in the same way medical care costs are now covered. The committee favored the greatest possible use of non-governmental facilities.

B. The individual programs planned for family care clients should be the joint responsibility of the institution staff, the community training and activity center staff, and the family care householder.

C. Adequate funds should be paid to the family care householder to cover the cost of transportation for daily attendance at a public or private training center, sheltered workshop, or employment.

D. The Department of Mental Health and the State Department of Public Welfare should jointly consider the best method of application for state financial resources and staff to avoid duplication in services.

E. Family care placement should not be restricted to the so-called legal residence of the client. Clients should not be forced for financial reasons to return to the place of commitment if another geographic area will offer a better set of resources for him.

F. The Family Care program in its present form cannot accommodate all the retarded persons in the institutions who could live in smaller homes. Additional funding and staffing schemes must be established to support the operation of the small group homes.

G. Payments from public welfare, social security, etc. should augment Family Care payments when appropriate.

CHAPTER VII

LICENSURE OF RESIDENTIAL FACILITIES

I. HISTORY OF LICENSING LAWS

II. ESTABLISHMENT AND ACTIVITIES OF AD HOC COMMITTEE

III. RECOMMENDATIONS

CHAPTER VII

LICENSURE OF RESIDENTIAL FACILITIES

I. HISTORY OF LICENSING LAWS

Early in the first year of the project, it was recognized that work had to be undertaken to assemble available knowledge and information about current licensing authority in Indiana. The major state departments were identified as the State Board of Health, the State Department of Public Welfare, and the Department of Mental Health (Appendix D). Under the Health Facilities Law, Chapter 239, Acts of 1963, the Health Facilities Council was created and given the responsibility of drawing up rules and regulations for the nursing home industry. The State Department of Public Welfare has licensing authority for foster homes and residential homes for children. The Department of Mental Health has authority under the 1955 Family Care Law to approve family boarding homes for patients placed through the 12 state hospitals and training centers for the retarded.

II. ESTABLISHMENT AND ACTIVITIES OF AD HOC COMMITTEE

A subcommittee on licensing was established and later expanded to include representatives from the Division of Nursing Home Licensing, State Board of Health.

This subcommittee worked with representatives of the state agencies in an attempt to convince them that the "traditional" medical facility did not meet the residential needs of the majority of retarded citizens. Only a small portion of the retarded population, requiring residential care services are in need of intensive nursing and/or medical supervision.

The retarded do have health problems, however, and licensing standards would be required. The standards need to be specified under new classes of facilities which reflect reasonable requirements for healthy development of retarded citizens in socio-personal as well as physical hygiene and care.

Following a slide presentation and discussion on December 16, 1971, it was decided to develop a licensing procedure for a type of group residential - vocational rehabilitation facility and to submit a formal proposal for licensing to the Health Facilities Council. The law, as was interpreted, appears to carry a provision for establishing new classes of facilities. The Health Facilities Council may then develop appropriate rules and regulations for these new classes as they are developed. The subcommittee was of the opinion that it would be better to pursue this route of going to the Council with a proposal, as opposed to writing new legislation.

The proposal was drawn up and with the assistance of the State Board of Health's personnel, was placed before the Council on March 15, 1972 (Appendix D). The Council read the proposal and referred the matter to a subcommittee for further study. The subcommittee met on March 18, 1972, and did accept the responsibility of developing new classes with appropriate regulations. The subcommittee plans on inviting the Department of Public Welfare, the State Fire Marshall, the Department of Mental Health and the Director of Vocational Rehabilitation to participate in future meetings. Consideration will be given to the various types of residential arrangements that have been developed for people living in "homes" other than their own and the development of appropriate "classes" under the broad authority of the Health Facilities Law. Recognition was given to the fact that such local authority exists only in some cases or under no licensing authority at the present time. The committee appears to accept the idea that many non-medical type facilities are the thing of the future and that the trend is definitely away from the large congregate care institution.

Major problems are anticipated in the following areas - the health administrators law and the use of existing two-story homes that currently are unacceptable as nursing homes as presently defined in the regulations. It is thought that many of these homes would be accepted for the type of individual and program currently being developed for the upper level retarded who are going to be in training programs and employment.

The Health Facilities Council under the Health Administrators Law has not seen fit to permit administrators to administrate groups of facilities. It was the thinking of this Committee that an ARC executive, for example, could provide proper administration for a number of facilities in his county or service area. Individuals acquainted with this planning program and with past experience on the licensing committee should be available and should be in a position to make some major inputs to this subcommittee's task. It is essential that the licensing subcommittee continue to work with the Health Facilities Council and the Indiana State Board of Registration and Education for Health Facility Administrators.

III. RECOMMENDATIONS

A. Continue the Licensing Committee, with representation from the Health Facilities Council, in order to develop appropriate standards for licensing all residential models.

B. Request that the Division on Mental Retardation "sponsor" the Licensing Committee, as an Ad Hoc Committee of the Division on Mental Retardation, in order to insure the continuation of this committee.

C. Suggest to the Health Facilities Council that official representation from this Licensing Committee be included on the sub-committee of the Health Facilities Council which is studying licensing of alternate facilities.

D. Establish contact with the State Board of Registration and Education for Health Facility Administrators in order to involve them in the planning of licensing standards.

CHAPTER VIII

LEGISLATION

I. PROJECT LEGISLATIVE ACTIVITY

II. RECOMMENDATIONS

CHAPTER VIII

LEGISLATION

I. PROJECT LEGISLATIVE ACTIVITY

It became apparent early in the life of the project that some of the most pressing residential crises facing the mentally retarded could be alleviated only through legislative action. There were few alternatives to institutional placement for those requiring residential services and the present state hospitals for the mentally retarded were unable to cope with the total program needs of their residents. In addition, there were many individuals who were certified eligible for institutional placement but because all the existing beds were filled, the only "service" the Department of Mental Health could offer was to place them on a waiting list.

The "long" 1971 legislative session was already underway when the Steering Committee arrived at a concensus regarding legislative remedies, but it resolved to identify and document those major problems for the 1972 Indiana General Assembly. During the summer and fall of 1971, therefore, the committee was consulted in the drafting of House Bill 1145 which authorized the Department of Mental Health to provide residential placement and services as an alternative to institutionalization of those on the waiting lists of the State Hospitals and Training Centers. The committee was also consulted in the framing of House Bill 1213, which authorized the Department of Mental Health to establish demonstration of community residential facilities.

The Steering Committee and Project Staff were also involved in the drafting of Senate Bill 149, which mandated the utilization of State and local funds to obtain maximum federal monies under the provisions of the Social Security Act. Not only did the Project participate in the drafting of these significant pieces of legislation, but its staff was called upon by the lawmakers to document these measures in both House and Senate committee hearings. All three measures passed the 1972 Legislature by overwhelming majorities (Appendix E).

II. RECOMMENDATIONS

The Steering Committee has identified three issues that may require legislation during the next session of the Indiana General Assembly:

A. Appropriations by the 1973 General Assembly to fund HB 1145 and HB 1213 enabling the Department of Mental Health

to fulfill its legal authority in serving those on the waiting lists with alternative community placements, and to develop a variety of model residential settings for demonstration purposes.

B. Mandate the Health Facilities Council, Indiana State Board of Health, to license small group homes for the mentally retarded.

C. The effectiveness of government policy making and its implementation as it affects handicapped persons is seriously impeded by the numbers of departments and divisions which are independently trying to serve the retarded. Therefore, legislation to mandate a single state department or establish a multi-department council to coordinate services for the retarded is vitally necessary.

CHAPTER IX

COMMUNITY EDUCATION AND PARTICIPATION

I. INTRODUCTION

II. WORKSHOPS

- A. Residential Care
- B. Advocacy

III. REGIONAL HEARINGS

IV. GUIDELINES FOR THE DEVELOPMENT OF A COMMUNITY RESIDENTIAL FACILITY

CHAPTER IX

COMMUNITY EDUCATION AND PARTICIPATION

I. INTRODUCTION

From the inception of the project, continual effort has been made by the project staff and Steering Committee to involve many individuals and agencies throughout the state in the development of concepts, activities, and final recommendations. The degree to which project recommendations are implemented will be greatly dependent on the interest and participation of state and local governmental, professional and voluntary individuals and agencies.

II. WORKSHOPS

A. Residential Care

Early in 1970, a conglomeration of health agencies determined together to sponsor the first conference on residential services for the mentally retarded in Indiana. The program was held on Saturday, June 27, 1970, in Indianapolis by:

1. Indiana Mental Health--Mental Retardation Planning Commission
2. President's Committee on Mental Retardation
3. Indiana Department of Mental Health
4. Indiana Comprehensive Health Planning Council
5. Indiana Association for Retarded Children

Approximately 150 persons were in attendance representing many public and private agencies and volunteer groups.

The keynote address was given by Dr. Wolf Wolfensberger on the subject "The Residential Services Model: Let's Break the Old and Build the New".

In the ensuing discussion groups and panels, a general enthusiasm for the development of more appropriate residential services in the State of Indiana was generated among all participants. It was at this time that the announcement was made that the application for the residential services study project had been approved. Thus, the June conference set the stage for the work which the INDIANA MENTAL RETARDATION RESIDENTIAL SERVICES PLANNING PROJECT would undertake and enlisted the support of many segments of the public and private sectors to translate ideas and concepts into action.

B. Advocacy

The Steering Committee had met only a few times when it became evident that a system of advocacy was a vital necessity in the

State of Indiana along with the development of community residential services and programs of habilitation for the mentally retarded. During the past few years, proposed legislation, White House Conference recommendations, and pilot-programs have evolved on the subject of advocacy.

In late 1971, after having heard and read bits and pieces about the various aspects of advocacy for the retarded, the Steering Committee proposed that a seminar be conducted to educate community leaders as to the implications of advocacy. The consensus was that the Steering Committee would not have time to develop a program, but that the Indiana Association for Retarded Children and the Mental Health--Mental Retardation Planning Commission should be made aware of the proposal with the anticipation that one could sponsor such a seminar or workshop. The proposal was approved by the Indiana Mental Health--Mental Retardation Planning Commission and a workshop planning committee was formed in early 1972.

The Indiana Workshop on Advocacy was held on April 13, 1972, in Indianapolis to explore advocacy-type programs in mental retardation as well as in the areas of the aged, alcohol and drug abuse, corrections, and child and adult mental health. Highlights of the meeting included addresses by Fred Krause, Deputh Executive Director of the President's Committee on Mental Retardation, and Thomas L. Shaffer, J. D., Dean of the Notre Dame School of Law.

It appeared that even though much was being presented at the national and local levels, there had not been a unified effort at the state level. Various agencies have been self-designated as "advocates" with the result being a confusion in which there were both duplicated efforts and gaps in the spectrum of advocacy concerns. It was discovered in the workshop that much ambiguity surrounds the word "advocacy" (collective and individual; legal, etc.); and it was felt that refinement of the use of the term and self-education processes among volunteers and professionals are prerequisites to developing a total advocacy system for the mentally retarded in the State of Indiana.

It was the consensus that the workshop was of great value in clarifying the advocacy concept, and it was recommended that further exploration of advocacy systems for the mentally retarded should be continued under the sponsorship of the Mental Health--Mental Retardation Planning Commission and/or Indiana Association for Retarded Children. Thus, the Steering Committee became the catalyst for developing this concern on the state level.

III. REGIONAL HEARINGS

To provide maximum citizen participation in the work of this committee and the changes it proposes in caring for the mentally

retarded, a total of sixteen hearings were held in the fourteen Mental Health-Mental Retardation Planning Regions during April and May 1972.

Extremely significant data was gathered during the first phases of the study and was included in the format of the hearings:

1. History of the project
2. Philosophy
3. Slide presentation of types of residential models, residents involved, and community programs.
4. Explanation and discussion of residential models.
5. Presentation of data collected in the region:

   a. Number of retarded identified as needing residential services, including those in state hospitals from the region.

   b. Breakdown of those identified by age group.

   c. Estimate of number of residential spaces needed in the region.

6. Discussion period.

The attendance ranged from 10-125. The media was usually well represented at the hearings and the project was given extensive coverage in press, radio and television.

The concept of normalization which underlies this change of service delivery apparently is in harmony with most people's values, as there were no major negative response. It is felt valuable and significant information was given to many different citizens throughout the state.

Evaluations were written by those Steering Committee members in attendance and are available for review.

Prior to the hearings, various communities and individuals had been exposed to the activities of the project. Presentations by the project staff and Steering Committee members were made at three regional meetings of the Indiana Association for Retarded Children in late 1971, as well as to several parent and teacher groups throughout the state and nation.

Two hundred and seventy-five interim reports were distributed to personnel of public and private organizations at the national,

state and local levels in the summer of 1971. Articles prepared by the staff were published in the IARC Newsletter and several national publications.

IV. GUIDELINES FOR THE DEVELOPMENT OF A COMMUNITY RESIDENTIAL FACILITY

To further assist community organizations who have either already or may in the future accept the obligation of providing residential care, guidelines have been written related to licensing procedures, cost of operation, programs and personnel standards for funding. To accommodate those who may want to refer regularly to these, all materials are published in Appendix F for convenience of removal from the total report.

It must be understood that it is quite difficult to establish the precise cost of developing and maintaining a small residential facility. It does appear that the cost per person will be no greater than the present cost of care in a state institution. The costs per day at Fort Wayne and Muscatatuck State Hospitals average close to $14.00; however, cost for some individuals may be quite nominal while treatment and medical care for others may far exceed the average. A variance in cost would also be applicable to those in the community homes, depending on the services required.

CHAPTER X

RECOMMENDATIONS

I. RECOMMENDATIONS FOR IMPLEMENTATION OF PROJECT PLAN

II. GOVERNMENTAL AGENCY RECOMMENDATIONS

III. SUMMARY OF OTHER RECOMMENDATIONS

- A. Chapter Six - Family Care
- B. Chapter Seven - Licensure
- C. Chapter Eight - Legislation

CHAPTER X

RECOMMENDATIONS

I. RECOMMENDATIONS FOR IMPLEMENTATION OF PROJECT PLAN

After carefully reviewing and analyzing Project Plan materials that have been compiled, and gathering a consensus of professionals as well as non-professionals on both the state and local levels, it appears that the most feasible plan for implementation is as follows:

THE DEPARTMENT OF MENTAL HEALTH, THROUGH THE DIVISION OF MENTAL RETARDATION, SHALL PROVIDE DIRECT AND/OR INDIRECT DELIVERY SYSTEMS DESIGNATED TO MEET THE NEEDS OF ALL MENTALLY RETARDED RESIDENTS IN INDIANA.

In order to further implement this recommendation, THE DEPARTMENT OF MENTAL HEALTH MUST FORMALLY ADOPT THE FINDINGS AND RECOMMENDATIONS OF THIS REPORT.

II. GOVERNMENTAL AGENCY RECOMMENDATIONS

A. Department of Mental Health immediately develop a plan for the implementation of legislation relating to residential services; i.e., HB 1145, HB 1213, and SB 149.

B. Department of Mental Health in cooperation with the Mental Health-Mental Retardation Planning Commission organize a study committee to consider a system of regionalization for the implementation of residential services.

C. Department of Mental Health establish a continuous review process of federal legislation which involves additional funding of supportive services for the mentally retarded.

D. Department of Mental Health and other state agencies providing services to the retarded should work jointly in developing a system of service which would avoid duplication and apply funds in service priorities.

E. Appointment of an Ad Hoc Committee of the Mental Health-Mental Retardation Planning Commission to study and recommend a state-wide system of advocacy for the mentally retarded.

F. Mental Health-Mental Retardation Planning Commission, through its regional committees, sponsor regular community hearings on the planning and implementation of programs for the mentally retarded in the respective region.

III. SUMMARY OF OTHER RECOMMENDATIONS

A. Chapter VI - Family Care

1. Department of Mental Health should pay for services, i.e., work activity, sheltered workshop, evaluations, therapy, and transportation which are not covered by the public school for an individual during Family Care placement.

2. Community program planning for a Family Care recipient should be the joint responsibility of institutional staff, family care householder and community center staff.

3. Regulations regarding receipt of financial resources based on legal residence of client should be altered if another geographic area is more feasible for client placement.

4. Public welfare, social security and other benefits should augment Family Care payments when appropriate.

B. Chapter VII - Licensure

1. Division of Mental Retardation should "sponsor" the licensing committee organized by the project to insure the continuous development of appropriate standards for the licensing of community residential facilities.

2. Request that a member of the licensing committee be appointed to the study committee for new regulations of the Health Facilities Council.

3. Involve the State Board of Registration and Education for Health Facility Administrators in the development of new licensing standards.

C. Chapter VIII - Legislation

1. Appropriation of funds necessary for the implementation of HB 1145, HB 1213, and SB 149.

2. Mandate the Health Facilities Council, Indiana State Board of Health, to establish licensing regulations for small community group homes for the mentally retarded. (If Health Facilities Council determines that licensing is not within its authority.)

3. Mandate a single state department or establish a multi-department council to coordinate services for the retarded.

APPENDICES

(APPENDIX A-1)

GOAL OF THE INDIANA MENTAL RETARDATION RESIDENTIAL SERVICES PLANNING PROJECT

TO ESTABLISH A PLAN WHICH WILL DELINEATE THE TYPES OF RESIDENTIAL FACILITIES NEEDED WITHIN A COMMUNITY OR SERVICE AREA WHICH WILL KEEP THE INDIVIDUAL IN HIS HOME COMMUNITY AND ENHANCE HIS HABILITATION THROUGH LOCAL TREATMENT, EDUCATIONAL AND VOCATIONAL PURSUITS.

(APPENDIX A-2)

HEALTH PROBLEM A: To provide the types and numbers of residential facilities to be developed in the State of Indiana for the mentally retarded.

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. By December 31, 1971 conduct survey of mentally retarded enrolled in community programs (ARC's, rehabilitation centers, workshops) throughout the state.	1.a. S. Turner and L. Foster will contact directors by telephone to make arrangements for recording needed data on survey forms, and set deadline for completion of each facility.	95% 100%	Two ARC directors have not responded after several contacts and deadlines have been set. One ARC only recently employed a new director who is completing them. Program Increment 1/25/72
	b. S. Turner or L. Foster will make any necessary visits for completing survey.	100%	All visits completed December 15, 1971.
	c. Surveys, as completed, returned to office project.	100%	All that have been completed were returned by December 15, 1971
2. By December 31, 1971 conduct survey of all public school special education programs in Indiana.	2.a. L. Foster will contact by telephone directors of special education to arrange for completion of surveys, and set deadline.	95% 100%	See remarks- 1.a. Program increment 1/7/72
	b. L. Foster will make any necessary visits to schools to record data.	100%	Visits completed Dec. 30, 1971
	c. Surveys as completed, returned to project office.	80% 100%	Due to school holidays, shortage of school personnel not as yet completed, but commitment on all but four school systems which have refused to cooperate. Program increment 3/25/72

(APPENDIX A-3)

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
3. By December 31, 1971 conduct survey in all state mental health hospitals.	3.a. S. Turner to obtain written authorization from Commissioner of M/H for purpose of reviewing files of mentally retarded in hospitals.	100%	Dr. Murray sent letter of introduction and authorization to all state hospital superintendents and records librarians, February 1971.
	b. S. Turner to contact Superintendents and librarians to determine most feasible method of gathering needed data.	100%	Contacts completed October 8, 1971.
	c. If additional individuals needed at hospital site for project, S. Turner will interview and employ.	100%	Additional individuals employed at Ft. Wayne and Muscatatuck.
	d. S. Turner to obtain from statistical division (Miss May) of M/H all M/R's reported to be residents of state hospitals	100%	Received all computer cards by March 1, 1971.
	e. S. Turner complete surveys and return them to project office.	100%	Completed October 20, 1971.
4. By December 31, 1971 conduct survey in all state correctional facilities	4.a. S. Turner to obtain authorization from Director of Research in Dept. of Corrections to review files of M/R's in facilities.	100%	Dr. Shrink sent letter of introduction and authorization to each institutional Superintendent, May 1971.
	b. S. Turner contact Superintendents to schedule visit to institutions,	100%	Contacts completed September 10, 1971.

(APPENDIX A-4)

OBJECTIVE		PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
	c.	S. Turner to visit institution, complete surveys and return them to project office.	100%	Completed September 28, 1971
5. By December 31, 1971 conduct survey of all nursing facilities serving the retarded.	5.a.	S. Turner and L. Foster contact directors of private nursing facilities as listed in IARC directory to schedule visit and survey.	100%	Completed November 1, 1971
	b.	S. Turner request assistance in writing of regional M/H - M/R executive secretaries in identifying nursing homes other than those in (1.) serving the retarded.	100%	Letters sent October 29, 1971
	c.	S. Turner and L. Foster or facility complete surveys part (5.a.) and return to office.	98%	One home has recently changed administrators and personnel, promise that survey will be completed.
	d.	K. Dollinger and L. Foster contact facilities as identified in (5.b.) and arrange for completion of survey.	100% 100%	program increment 2/1/72 Completed December 10, 1972
	e.	L. Foster visit facility; complete and return surveys.	100%	Completed December 21, 1971
6. All forms computerization by January 15, 1972.	6.a.	Within 5 days of returning forms to office, S. Turner, L. Foster and/or K. Dollinger will review them to determine if forms are completed in entirety. If additional information needed it will be obtained by telephone.	100%	Ongoing process program increment 2/29/72

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(APPENDIX A-5)

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
	b. Staff personnel will deliver forms to Indiana University computer service.	100%	Ongoing process Program increment 3/15/72
7. Analysis of computerized data by February 25, 1972.	7.a. S. Turner to develop exact information to be drawn from survey and notify P. T. Hodgins (programmer) so data can be recorded.	100%	Completed January 27, 1972
	b. Data will be analyzed by L. Foster and S. Turner by the 14 M/H - M/R regions to determine the types and number of residential facilities needed in each area as indicated by need of various types of treatment.	100%	Completed March 20, 1972
8. Steering Committee will approve of types and numbers of residential facilities by March 24, 1972.	8.a. S. Turner will present report to Steering Committee members at March, 1972 meeting.	0 100%	March meeting not held Program increment 4/11/72
	b. Committee to take action on report at March, 1972 meeting.	0 100%	March meeting not held Program increment 4/11/72

(APPENDIX A-6)

HEALTH PROBLEM 8: To provide licensing standards for the various types of residential facilities.

NOTE: Plan set forth as relates to residential facility for higher functioning young adult - when other facility types identified, similar plan of action will be developed.

OBJECTIVE		PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. Model for higher functioning young adult (vocational-educational residential facility) will be described by January 31, 1971.	1.a.	R. Jones, R. Reichard and S. Turner will develop general concept of such a facility (clients, treatment program and administration).	100%	Meeting held and concept written November 16, 1971
	b.	Presentation of above concept to licensing committee for reaction by above same individuals.	100%	Presented November 24, 1971
	c.	Refinement of concept and presentation to Steering Committee for reaction by S. Turner, R. Reichard and F. Ryan.	100%	Completed January 11, 1972
2. Personnel qualifications for facility will be developed by February 29, 1971.	2.a.	Marion County Residential Study Committee and project licensing committee will review present personnel qualifications for this type facility as now existing in this state and others. S. Turner will provide committee with material.	100%	Completed February 2, 1972
	b.	Study committee will develop personnel qualifications.	100%	Completed February 24, 1972
	c.	Project steering committee will approve qualifications.	100%	Completed February 15, 1972
3. By February 29, 1972 present proposal to Fire Marshall's office for review.	3.a.	S. Turner, R. Reichard present regulations and recommend revisions.		Determined not necessary April 29, 1972

(APPENDIX A-7)

OBJECTIVE		PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
4. Proposal for adoption of residential facility standards will be made to Health Facilities Council by March 15, 1972.	4.a.	S. Turner, R. Reichard will contact licensing officials to schedule meeting for introductory presentation of concept for new licensing standards.	100%	Visit to ISBH November 29, 1971 Meeting scheduled for Dec. 16
	b.	Presentation to director of licensing and State Board of Health attorney will be given by R. Jones, R. Reichard and S. Turner at study committee meeting.	100%	V. Koonce, G. Ramsey, Dr. Edwards and W. Christen from ISBH present. December 16, 1971
	c.	Licensing Committee will prepare final audio visual and written proposal for Health Facilities Council. (J. Huffer, R. Jones, R. Reichard, F. Ryan, and S. Turner.)	100%	Completed February 24, 1972
	d.	S. Turner prepare materials to be mailed to Health Facilities Council members prior to meeting (March 1, 1972).	100%	Completed March 1, 1972
	e.	Presentation to Health Facilities Council at its meeting March 15, 1972.	100%	Completed March 12, 1972 Special study committee appointed by Council

(APPENDIX A-8)

HEALTH PROBLEM C: To provide legislation to appropriate funds for establishment of community residential facilities.

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. Committee determine general contents of legislation by October 1, 1971.	1.a. Steering committee use 1971 proposal as guide.	100%	Completed October 27, 1971
2. Draft of legislation adopted by committee by November 30, 1971.	2.a. S. Turner obtain from facilities presently operating cost analysis.	100%	Data all obtained by November 10,1971
	b. S. Turner and R. Cutter write legislation.	100%	Completed November 1, 1971
	c. Committee reaction at November Steering Committee meeting.	100%	November 23, 1971- no objections as written
3. All requirements for introduction of legislation to legislature completed by January 11, 1972.	3.a. Ron Cutter (IARC) submit legislation to legislative council for final draft.	100%	Completed Novermber 30, 1971
	b. R. Cutter solicit and obtain sponsorship of legislation.	100%	House Bill 1213 introduced by Jerome Kearns - December 1971
4. Steering Committee members and project staff support legislation until legislative determination by February 18, 1972.	4.a. S. Turner provide all steering committee members with finalized formal copy of legislation at January steering committee meeting.	100%	January 11, 1971
	b. S. Turner prepare written and oral report which substantiates need for legislation.	100%	1/14/72
	c. Dr. Meyer, S. Turner appear at legislative hearings and present documented data.	100%	1/14/72 - Passed House Comm. 2/7/72 - Passed Senate Comm.

(APPENDIX A-9)

HEALTH PROBLEM D: To provide legislation which authorizes the Department of Mental Health to finance residential placement and services as an alternative to institutionalization of the mentally retarded.

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. Committee determine general contents of legislation by October 1, 1971.	1.a. Steering committee use 1971 proposal as guide.	100%	Completed October 27, 1971
2. Draft of legislation adopted by committee by November 30, 1971.	2.a. S. Turner obtain from facilities presently operating cost analysis.	100%	Data obtained by November 10, 197·
	b. S. Turner and R. Cutter write legislation.	100%	Completed November 1, 1971
	c. Committee reaction at November steering committee meeting.	100%	November 23, 1971- no objections as written.
3. All requirements for introduction of legislation to legislature completed by January 11, 1972.	3.a. Ron Cutter (IARC) submit legislation to legislative council for final draft.	100%	Completed November 30, 1971
	b. R. Cutter solicit and obtain sponsorship of legislation.	100%	House Bill 1145 introduced by J. Jeff Hays. December 1971
4. Steering Committee members and project staff support legislation until legislative determination by February 18, 1972.	4.a. S. Turner provide all steering committee members with finalized formal copy of legislation at January steering committee meeting.	100%	January 11, 1971
	b. S. Turner prepare written and oral report which substantiates need for legislation.	100%	1/20/72
	c. Dr. Meyer, S. Turner appear at legislative hearings and present documented data.	100%	1/20/72 - Passed House Comm. 2/3/72 - Passed Senate Comm.

(APPENDIX A-10)

HEALTH PROBLEM E: To proivde a system for financing community residential facilities.

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. By December 31, 1971 review Family Care program financing.	1.a. Family Care ad hoc Committee develop figures and recommendations regarding future funding or expansion of services.	100%	Completed November 1, 1971
	b. D. Lindegren prepare report for Steering Committee review.	100%	Completed December 15, 1971
	c. Project staff distribute above report to committee members.	100%	Mailed December 20, 1971
2. By December 31, 1971 review DPW financing which could be involved in community facilities.	2.a. Same as 1.a.	100%	same as 1.a
	b. Same as 1.b.	100%	same as 1.b.
	c. Same as 1.c.	100%	same as 1.c.
3. By January 11, 1972 develop legislation to appropriate funds for establishment of community facilities.	3.a. As stipulated in Health Problem C.	100%	2/7/72
4. By January 31, 1972 review federal and state funding available for operation of community facilities.	4.a. Committee members explore funds available through social security administration (J. Austin and L. Thorn).	100%	Senate Bill 149 introduced by Senator Helmke. January 1971.
	b. S. Turner gather material on available funds through various departments of HEW and departments in Indiana.	100%	1/11/72
	c. Material from 4.a. and 4.b. be presented to Steering Committee.	100%	1/11/72

(APPENDIX A-11)

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
5. By March 25, 1972 Steering Committee develop plan for financing of community residential facilities.	5.a. Dr. Meyer appoint ad hoc committee to work with project staff on financial plan.	100%	3/1/72
	b. Present plan at March Steering Committee meeting.	-0-	Meeting not held. Program increment 100% 4/11/72

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(APPENDIX A-12)

HEALTH PROBLEM F: The project will co-sponsor with the Mental Health-Mental Retardation Planning Commission an advocacy workshop.

OBJECTIVE		PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. Presentation of proposal for workshop to planning commission by November 30, 1971.	1.a.	S. Turner make presentation to commission at its November meeting.	100%	Commission accepted proposal, November 23, 1971
2. Planning Committee organized by January 31, 1972.	2.a.	Dr. Meyer and Mr. Binford will appoint committee.	100%	Committee: F. Ball, B. Faulkey, R. Kiefer, F. Osberg, F. Ryan, S. Turner. Meeting scheduled 1/18/72 Dec. 16, 1971
	b.	S. Turner to schedule meeting and notify committee members.	100%	
3. Workshop to be held by April 15, 1972.	3.a.	Committee to determine at first meeting the format, location, date, prospective participants and who to be invited to attend. Schedule second meeting.	100 %	1/20/72
	b.	Committee members confirm participation of guest speakers.	100 %	2/22/72
	c.	S. Turner confirm location.	100%	1/26/72
	d.	Project staff prepare and mail announcement of workshop.	100%	3/2/72
	e.	Project Steering Committee members and commission members will attend and participate in workshop.	100%	4/13/72

(APPENDIX A-13)

HEALTH PROBLEM G: To provide regional meetings throughout the State of Indiana to educate the citizenry on community residential services for the retarded.

OBJECTIVE	PLAN OF ACTION	EVALUATION	REMARKS
1. Organize committee for arranging regional meetings by February 15, 1972	1. S.Turner will meet with regional M/H-M/R executive secretaries to solicit their cooperation in making local arrangements; date, meeting place and mailing list for notices of meeting.	100%	Completed 2/3/72
2. Steering Committee will approve material included in community presentations by April 14, 1972	2a. S. Turner and L. Foster will prepare commentary to be presented with slides.	100%	Completed 4/10/72
	b. L. Foster will arrange for rental of audio-visual equipment	100%	Completed 3/20/72
3. Fourteen regional presentations to be completed by May 29, 1972	3a. Schedule presentations to be made by project staff during the period April 17, 1972 and May 29, 1972.	100%	Completed 3/20/72
	3b. Designate Steering Committee members to attend each of the hearings.	100%	Completed 4/11/72
	3c. After each meeting, project staff and committee members prepare analysis of reaction by those in attendance.	94% 100%	One hearing not held until May 31, 1972 Program increment 5/31/72

(APPENDIX A-14)

HEALTH PROBLEM H: To provide guidelines for the establishment of community residential facilities.

OBJECTIVE	PLAN OF ACTION (METHOD)	EVALUATION	REMARKS
1. By February 15, 1972 prepare outline of topics to be included in guideline.	1.a. Collect and review guidelines as prepared by other states (S. Turner and L. Foster).	100%	Completed Feb. 15, 1972
2. By March 14, 1972 complete initial draft of guidelines.	2.a. S. Turner obtain information from licensing agencies in state.	100%	Completed February 1, 1972
	b. L. Foster obtain fire marshall regulations.	100%	Completed March 1, 1972
	c. L. Foster obtain zoning ordinances from various size communities.	100%	Completed March 7, 1972
	d. S. Turner and L. Foster review materials (a. b. c.) and prepare summary for guidelines.	100%	Completed March 10, 1972
	e. S. Turner prepare some cost figures on operation of various types of facilities.	100%	Completed March 10, 1972
	f. L. Foster set forth brief description of various types of residential facilities	100%	Using those developed 5/71
	g. Present to Steering Committee for approval at March meeting (S. Turner and L. Foster).	0 100%	Meeting not held Program increment 4/11/72
3. By May 29, 1972 distribute guidelines to public and private mental retardation organizations.	3.a. S. Turner contact Ft. Wayne State Hospital regarding printing of outlines.	100%	Completed March 28, 1972
	b. L. Foster prepare listings of those agencies to whom guidelines should be forwarded.	100%	Completed April 1, 1972

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OBJECTIVE	PLAN OF ACTION	EVALUATION	REMARKS
	c. S. Turner and L. Foster distribute guidelines at regional meetings	94% 100%	Program increment 5/31/72
	d. Project secretary prepare and mail guidelines not distributed at regional meetings.	94% 100%	Program increment 6/1/72

(APPENDIX B-1)

1 Card Code

2 4 Facility Code

Date of Report

PERSONAL INVENTORY

5 8 IDENTIFICATION OF INDIVIDUAL

NAME OR IDENTIFICATION NUMBER

9 10 AGE OF INDIVIDUAL

11 SEX 0. Female 1. Male

12 RACE 0. White 1. Negro 2. Spanish American 3. Indiana 4. Oriental

13 14 PRESENT RESIDENCE:

A. County Code (if enrolled in state institution give county of commitment)

15 B. Location of bed and board for greater portion of week:

0. Natural Home
1. State Institution
2. Foster Care
3. Family Care
4. Nursing Facility
5. Other, Specify _____

16 RANGE OF MENTAL RETARDATION (as defined by attached)

0. Borderline
1. Mild
2. Moderate
3. Severe
4. Profound
5. Unknown

INDICATE THOSE PHYSICAL AND/OR MENTAL DISABILITIES IN ADDITION TO MENTAL RETARDATION WHICH REQUIRE SPECIAL CARE IN EDUCATIONAL, MEDICAL, EMPLOYMENT, AND/OR RESIDENTIAL ACTIVITIES

17 1. Psychosis 18 1. Neurosis 19 1. Other Behavior problems (ex. overtly aggressive)

20 1. Epilepsy 21 0. Controlled 1. Uncontrolled

22 1. Diabetes 23 0. Controlled 1. Uncontrolled

24 1. Orthopedic (as defined by attached)
25 0. a 1. b

26 1. Blindness (as defined by attached) 27 1. Deafness(as defined by attached)

28 1. Alcohol misuse (as defined by attached) 29 1. Drug misuse (as defined by attached)

30 1. Terminal condition requiring constant bed and nursing care

31 1. Others, specify _____

(APPENDIX B-2)

NATURAL HOME CARE

32 0. YES 1. NO A. If major appropriate services were available in the community are there family members willing and physically/emotionally able to care for this client in the home.

33 0. YES 1. NO B. Would family need financial assistance to adequately provide needed medications, treatments, services, etc.

RESIDENTIAL CARE

A. If client is presently residing in the natural home, or if appropriate services were provided and client discharged by the institution to the home, it is foreseeable that permanent residential care might be needed:

due to family health, attitude, etc.

34 0. less than 5 years 1. 5-10 years 2. 11-15 years 3. 16+ 4. do not know

due to family financial status

35 0. less than 5 years 1. 5-10 years 2. 11-15 years 3. 16+ 4. do not know

B. If client is not presently residing in natural home and no family members are capable or willing to care for individual, would placement in a community residential facility be feasible presently or in the foreseeable future (5 years).

36 0. Yes 1. No 2. do not know

AGE OF INDIVIDUAL PRESENTLY ASSUMING PRIMARY RESPONSIBILITY OF THIS CLIENT

37 A. Mother 0. 20-30 1. 30-40 2. 40-50 3. 50-55 4. 55-60 5. 60-65 6. above 65 7. don't know

38 B. Father 0. 20-30 1. 30-40 2. 40-50 3. 50-55 4. 55-60 5. 60-65 6. above 65 7. don't know

39 C. Guardian 0. 20-30 1. 30-40 2. 40-50 3. 50-55 4. 55-60 5. 60-65 6. above 65 7. don't know

40 1. There is no one assuming responsibility

41-42 IF PRESENTLY HOSPITALIZED INDICATE YEAR OF INSTITUTIONALIZATION ' ' '

(APPENDIX B-3)

SERVICES (as defined by attached)

	Presently receiving		need presently or in foreseeable future (5 yrs)
9	1. Diagnostic or evaluation	32	1.
10	1. Pre-school	33	1.
11	1. Education for school age and adults	34	1.
12	1. Work Activity	35	1.
13	1. Sheltered workshop	36	1.
14	1. Sheltered employment	37	1.
15	1. Home-bound services	38	1.
16	1. Maintenance of life	39	1.
17	1. Self-care, self-help	40	1.
18	1. Nursing care	41	1.
19	1. Physical therapy	42	1.
20	1. Speech therapy	43	1.
21	1. Occupational therapy	44	1.
22	1. Family therapy	45	1.
23	1. Psychiatric counseling	46	1.
24	1. Social and/or vocational counseling	47	1.
25	1. Structured-correctional supervision	48	1.
26	1. Summer Day camp	49	1.
27	1. Residential camp	50	1.
28	1. Correctional programming	51	1.
29	1. Crisis assistance	52	1.
30	1. Other, specify	53	1.
31	1. Recreational therapy	54	1.

(APPENDIX B-4)

MENTAL RETARDATION

Mental retardation refers to subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of mental retardation relates to IQ as follows:

Borderline mental retardation	IQ 68-83
Mild mental retardation	IQ 52-67
Moderate mental retardation	IQ 36-51
Severe mental retardation	IQ 20-35
Profound mental retardation	IQ under 20
Unspecified mental retardation	

These classifications are based on the statistical distribution of levels of intellectual functioning for the population as a whole. The range of intelligence subsumed under each classification corresponds to one standard deviation, making the heuristic assumption that intelligence is normally distributed. It is recognized that the intelligence quotient should not be the only criterion used in making a diagnosis of mental retardation or in evaluating its severity. It should serve only to help in making a clinical judgment of the patient's adaptive behavioral capacity. This judgment should also be based on an evaluation of the patient's developmental history and present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

Unspecified mental retardation is reserved for patients whose intellectual functioning has not or cannot be evaluated precisely, but which is recognized as clearly subnormal.

Reference: Diagnostic and Statistical Manual of Mental Disorders Second Edition, American Psychiatric Association, pages 14 and 15.

(APPENDIX B-5)

DEFINITIONS

orthopedic - (a) confined to wheel chair; must be assisted in the use of braces, walker, etc; crippling condition of arms and hands which restricts the handling of most objects.

(b) even though no specific crippling condition exists, individual would have difficulty in excessive walking, climbing of stairs, etc.

blindness - central visual acuity of 20/200 or less in better eye, with correcting glasses and is using or would benefit from the use of Braille.

deafness - those in whom the sense of hearing is nonfunctional for the ordinary purposes of life (must be at least 25% loss in best ear).

alcohol misuse- consumption of alcohol interferes with daily activity and interpersonal relations.

drug misuse - consumption of any drug interferes with daily activity and interpersonal relations.

diagnosis and evaluation - to substantiate existance and level of retardation and prognosis for treatment.

pre-school - structured program in which retardates develop behavior patterns, psycho-motor and self-help skills for children younger chronologically than school age.

education or training for school age - programs directed by either the school system, institution, and/or private agency for all levels of retardation. Training includes language and motor-development, socialization and self-care.

work activity - individual must be at least 16 years of age and participating in therapeutic activities with purpose of preparing him for enrollment in a sheltered workshop or employment.

sheltered workshop - adult at least 16 years of age and enrolled for purpose of determining the most feasible area of training and/or placement.

sheltered employment - program in which individual is compensated for his work, but is closely supervised either in sheltered workshop or on-the-job training due to individual's inability to function independently without some difficulty on a work assignment.

home-bound services - medical, educational or vocational services administered by qualified personnal to the retarded individual in the home.

maintenance of life - due to severity of handicap(s) individual requires medical services for survival.

self-care, self-help - individual quite limited in learning ability but may respond to minimal training in self-care.

nursing care - individual requires supervision and help from nursing personnel.

physical therapy - in addition to retardation individual is physically impaired and can benefit from treatment under the auspices of a registered physical therapist.

speech therapy - individual possesses difficulty in oral communication and needs speech services of a therapy program directed by a licensed speech therapist.

recreational therapy - activities in recreation, music, drama, dance, arts, and crafts which enhance the socialization of the individual, under auspices of a recreational therapist.

occupational therapy - therapeutic and occupational activities other than those generally provided in the work activity or sheltered workshop programs is administered or under supervision of a registered occupational therapist.

family therapy - counseling with family members by individual who is experienced in field of mental retardation and has concept of family attitudes, etc. regarding mental retardation.

psychiatric counseling - provisions for individual experiencing severe emotional crisis to be counseled by trained and experienced psychologists and/or psychiatrists

social and/or vocational counseling - periodically individual will be confronted with social situations which requires special supervision, guidance, and adjustment. This also includes assistance in job placement and understanding of employment responsibilities, etc. Those providing such services must be trained and experienced in such counseling

summer day and residential camp - emphasis on physical, recreational, educational and social activities which are not afforded or are supplemental to other programs.

correctional programming - close supervision with program emphasis on correction of anti-social behavior and related discipline problems.

crisis assistance - full or part day care needed due to temporary parental illness, death, vacations, etc.

(APPENDIX C-1)

FAMILY CARE PLACEMENT - PROGRESS

1971	CENTRAL *(APRIL)	FT. WAYNE (JAN.)	LOGANS-PORT (MAY)	MUSCA-TATUCK (APRIL)	NEW CASTLE (MAY)
Total institution population with mental retardation diagnosis.	135	2258	231	1906	851
Total in Family Care program with mental retardation diagnosis for period: July 21 - August 20, 1970 (same for information below).	2	152	19	216	98
Total still placed.	2	150	16	203	90
Total returned to institution for residence.	0	2	3	13	8
Least period in institutional residence before placement.	11 yrs.	2 wks.	4 mos.	1 mo.	3 yrs.
Longest period in institutional residence before placement.	15 yrs.	63 yrs.	29 yrs.	50 yrs.	59 yrs.
Total in institutional residence at least 25 years before placement that have not returned for residence.	0	30	1	58	41
Total in institutional residence at least 25 years before placement that have returned for residence.	0	0	0	6	2
Total in institutional residence one year or less before placement that have not returned for residence.	0	20	2	22	0
Total in institutional residence one year or less before placement that have returned for residence.	0	0	0	1	0

*Month statistics completed
I.M.R.R.S.P.P.

5/31/71

(APPENDIX C-2)

FAMILY CARE PLACEMENT - PROGRESS

	1971	BEATTY *(JULY)	N.I.C.H. (AUGUST)	MADISON (AUGUST)	RICHMOND (JULY)	EVANSVILLE (OCT.)	TOTAL
Total institution population with mental retardation diagnosis.		154	172	171	106	68	605
Total in Family Care program with mental retardation diagnosis for period: July 21 - August 20, 1970 (same for info below).		6	22	19	2	19	355
Total still placed.		5	21	17	2	13	519
Total returned to institution for residence.		1	1	2	0	6	36
Least period in institutional residence before placement.		1 yr.	2 wks.	3 mos.	3 yrs.	1 mo.	
Longest period in institutional residence before placement.		14 yrs.	10 yrs.	48 yrs.	21 yrs.	26 yrs.	
Total in institutional residence at least 25 years before placement that have not returned for residence.		0	0	7	0	1	133
Total in institutional residence at least 25 years before placement that have returned for residence.		0	0	0	0	0	8
Total in institutional residence one year or less before placement that have not returned for residence.		1	4	1	0	3	51
Total in institutional residence one year or less before placement that have returned for residence.		0	0	1	0	0	2

*Month statistics completed
I.M.R.R.S.P.P.
10/22/71

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(APPENDIX D-1)

LICENSING FACILITIES LAWS

I. HEALTH FACILITIES REGULATIONS
(Acts of 1963, Revised 1970)

The law empowers the State Board of Health to license and regulate "health facilities" as defined: means and shall be construed to include any building structure, institution, or other place, for the reception, accommodation, board, care or treatment extending beyond a continuous twenty-four hour period in any week of more than two unrelated individuals requiring, in apparent need of, or desiring such services or combination of them, by reason of age, senility, physical or mental illness, infirmity, injury, incompetency, deformity, or any physical, mental or emotional disability, or other impairment, illness or infirmity not specifically mentioned hereinabove, and shall include by way of illustration, but not in limitation thereof, institutions or places furnishing those services usually furnished by places or institutions commonly known as nursing homes, homes for the aged, retirement homes, boarding homes for the aged, sanitariums, convalescent homes, homes for the chronically ill, homes for the indigent: Provided, however, that the reception, accommodation, board, care or treatment in a household or family, for compensation of a person related by blood to the head of such household or family, or to his or her spouse, within the degree of consanguinity of first cousins, shall not be deemed to constitute the premises in which the person is received, boarded, accommodated, cared for or treated, a health facility: Provided, further, that any state institution or any municipal corporation may specifically request such licensure and upon compliance with all sections of this act and upon compliance with all existing rules and regulations, the petitioning facility may then be so licensed under the provisions of this act.

The term "health facility" within the meaning of this act, shall not mean or be construed to mean or include, respectively, hotels, motels, or mobile homes when used as such, hospitals, mental hospitals, institutions operated by the federal government, boarding homes for children, schools for the deaf or blind, day schools for the retarded, day nurseries, children's homes, child placement agencies, offices of practitioners of the healing arts, offices of Christian Science practitioners, industrial clinics providing only emergency medical services or first-aid for employees, and any hospital, sanatorium, nursing home, rest home, or other institution wherein any health care services and private duty nursing services are rendered in accordance with the practice and tenets of the religious denomination known as the Church of Christ Scientist.

Such licensing and regulation is accomplished through the Indiana Health Facilities Council comprised of 15 members:

2 from medical profession (Licensed)
1 registered nurse
1 hospital administrator
3 nursing care proprietors
3 persons operating philanthropic homes for aged
1 pharamacist
1 optometrist
1 person recommended by state director of DPW
1 person recommended by state fire marshall
1 person recommended by state health commissioner

As well as issuing license the board has power to revoke license. Legal penalties are also stipulated.

TYPES OF CARE AND REGULATIONS

A. Residential Care

1. The facility provides room, food, and laundry.
2. Persons admitted and residing in the facility are ambulatory and physically and mentally capable of managing their own care and affairs, but occasionally may need assistance with meals, dressing locomotion, bathing or other personal needs (shaving, combing hair, eliminative functions, etc.) short of nursing care (as defined in C below).
3. There is general supervision of the physical well-being of the persons residing in the facility. There is supervision of self-administered medications which have been obtained by the resident from his own physician. A residential care facility does not admit for residence a person who requires comprehensive nursing care. If a resident in this type of facility becomes in need of nursing care, he will be transferred from the facility.

B. Boarding Home for the Aged

The term "Boarding Home for the Aged" shall mean a health facility which provides only maintenance services to include food, shelter and/or laundry.

1. The homes provide room, food, and/or laundry only.
2. Persons residing in the home are capable of managing their own care, medications and affairs.
3. Persons residing in the home are physically and mentally capable of independently walking a normal path to safety, including the ascent and/or descent of stairs.

C. Comprehensive Nursing Care
Comprehensive nursing care includes:

1. Administration of medications (e.g., oral, rectal, hypodermic, or intra-muscular), shall be under the supervision and responsibility of an attending physician and the supervisory nurse.
2. The accomplishment of treatments (e.g., enemas, irrigations, catheterizations, application of dressing or bandages, supervision of special diets and other treatments involving a like level of complexity and skill).
3. Objective observation of changes in patient condition, including mental disturbance and senility, as a means for analyzing and determining nursing care required and/or the need for further medical diagnosis and treatment.
4. Restorative measures (passive and active exercise, proper body alignment for all patients, assistance to patient in doing for himself within his capability and other measures involving a like level of complexity and skill).

D. Combination Residential and Comprehensive Care Facility

Any facility so classified shall comply with regulations as follows:

The residential section or unit shall be in compliance with A. The comprehensive nursing care section or unit shall be in compliance with C.

E. Extended Care Facility

The term "Extended Care Facility" shall mean any health facility licensed under State law as a comprehensive care facility as defined in C above, and which meets Federal regulations for certification pursuant to the provisions of P.L. 89-97, as amended.

F. Nursing Care for Children

Children, for the purpose of this regulation, are defined as individuals who, by reason of physical or mental handicaps require nursing care of the type usually associated with pediatric care, who are less than eighteen (18) years of age or, if older, are suffering from a handicap or ailment which, in the judgement of the admitting physician, renders their care in a child care institution more appropriate than in an adult nursing care health facility.

(APPENDIX D-4)

Health, Medical, Dental and Nursing Care

1. The direct medical or dental care of the children not having a private physician or dentist shall be under the guidance of a qualified physician or dentist, or the medical director of the referring institution.
2. Each facility shall provide a written plan outlining the procedures for staff to follow in cases of illness and in emergencies, and this plan shall be available to all staff members.
3. Each child shall have a complete physical including intradermal Mantoux skin test for tuberculosis and dental examination in addition to an evaluation of his mental and physical capabilities prior to admission to the facility. Written orders from the attending physicians shall be available for each child's medication, diet, activities and treatment.
4. Each child upon admission shall show evidence of a completed immunization series for diphtheria, tetanus, smallpox, whooping cough, measles, and polio depending upon the age of the child. A planned program for booster immunizations shall be included in the care program.

REGULATIONS

In addition to specifying personnel and building regulations the following are also indicated:

A. All facilities will provide auxiliary social and group work services, medical and rehabilitation services, and other services which will help the patient or resident attain the level of functioning of which he is capable and realize his fullest potentials socially, emotionally, spiritually and physically.

B. Every health facility shall develop a method of in-service training for all personnel engaged in patient care to be assured that they understand the proper method of carrying out necessary procedures. No nursing personnel shall perform duties for which they have not had proper training.

C. Facilities in any classification established hereunder shall comply with all regulations of the State of Indiana pertaining to housing, fire safety, sanitation, and food service.

(APPENDIX D-5)

II. LICENSING OF BOARDING HOMES FOR CHILDREN,DAY NURSERIES, CHILD CARING INSTITUTIONS, CHILDREN'S HOMES, AND CHILD PLACING AGENCIES (Acts of 1945)

The law empowers Department of Public Welfare to license after licensee is approved by State Board of Health. Also, there is power of revokation and penalty.

It shall be unlawful for any person, firm, corporation or association to operate, maintain or conduct a boarding home for children, a day nursery, a children's home or child caring institution or to engage in or assist in conducting a business of placing children as herein defined, without having in full force a written license therefor from the State Department of Public Welfare. Provided, That nothing in this act shall apply to any state institution maintained by the state.

BOARDING HOME FOR CHILDREN

A boarding home for children is defined as the place of residence of a person who for hire, gain or reward has in his custody or control a child, unattended by parent or guardian, except a child related by blood or marriage, for the purpose of providing him with care, food or lodging.

DAY NURSERY

A day nursery is defined as any institution operated for the purpose of providing care and maintenance to children separated from their parents or guardian or a person in loco parentis during a part of the day for two or more consecutive weeks, excepting a school or other bona fide educational institution.

CHILDREN'S HOME OR CHILD CARING INSTITUTION

A children's home or child caring institution is defined as any children's home, orphanage, institution or other place maintained or conducted by any group of persons, a firm, association or corporation engaged in receiving and caring for dependent, neglected, handicapped children or children in danger of becoming delinquent or in operating for gain a private business of boarding children who are unattended by parents or guardian, or person in loco parentis.

CHILD PLACING AGENCY

A child placing agency is defined as any person, association or corporation who advertises himself or itself or holds himself or itself out as placing or finding homes for or otherwise disposing of children or assists in placing in homes of persons other than relatives or causes or assists in causing the placement for adoption or disposal otherwise of children.

(APPENDIX D-6)

The State Department of Public Welfare shall be responsible for the development of adequate standards of child care and, after consultation with the State Board of Health and State Fire Marshal, shall make, prescribe and publish such rules and regulations governing child welfare agencies and boarding homes, consistent with the provisions of this act, as shall be deemed necessary or advisable to protect the best interests of minor children, and to carry out the purpose of act after such rules and regulations are approved and adopted according to law. In order to improve standards of child care, the State Department of Public Welfare shall also cooperate with the governing bodies of child welfare agencies and institutions as defined herein and assist the staffs thereof through advice on progressive methods and procedures and suggestions for the improvement of services.

III. FAMILY CARE
(Acts of 1955, 1957, 1959, 1961, 1969)

The Family Care program was established 16 years ago and has remained under the auspices of the Indiana Department of Mental Health. Individuals placed in the Family Care program have been hospitalized and identified as being mentally ill or retarded, and remain on the hospital rolls as long as they are on Family Care. Family Care is used by those not requiring full hospital care, but as yet are unable to make an adjustment to independent living.

TYPES OF FACILITIES

A. Private Family Home - 1-5 patients.

B. Group Board Home - 6-12 patients. All must be ambulatory and meet minimal standards of self-care.

C. Halfway Houses - will approve if meeting minimal standards. Must be non-profit organization.

D. Residential Nursing Homes - patients require skilled care, but no longer require hospital or medical services. Must be licensed by Indiana State Board of Health.

F. Residential Child Care Institutions - if approved by DPW may be used. Placement is dependent upon treatment potential of staff and program.

All types of Family Care facilities will be evaluated by a social worker from one of the hospitals located in the same district as the facility. Family Care facilities may be terminated for lack of cooperation.

(APPENDIX D-7)

IV. STATE FIRE MARSHALL CODE

The following criteria is set forth for group boarding homes by the State Fire Marshall's office and is also applicable to private housing under the Family Care program.

A. There shall be two (2) means of egress from the first floor in every facility.

B. The wiring must be certified by a competent electrician to be safe and in good condition.

C. The heating unit must be certified by a competent heating contractor to be in good condition.

D. There shall be no accumulation of trash or debris in any area of the home.

E. The home should be neat and well kept.

F. If the home has a capacity of fifteen (15) or more and these occupants sleep on the second floor or in the basement, there shall be two (2) means of egress from these areas.

G. If the home has a capacity of more than ten (10), then the furnace room shall be enclosed with one (1) hour fire-resistive material. (This is subject to review by the State Fire Marshall.)

H. If at the time of inspection the fire inspector notes any serious fire hazard, it shall be corrected immediately.

I. Each occupant in each facility shall be capable of independent action and not need the assistance of another.

J. There shall never be any accumulation of grease in or around cooking area.

K. If deemed necessary by the fire inspector, an approved fire extinguisher shall be installed.

L. There shall be no flammable liquids stored within the facility.

M. All occupants must be familiar with exit facilities.

N. If twenty (20) or more patients are located within the facility, then all restrictions set forth in N.F.P.A. No. 101, "Life Safety Code," shall apply.

O. If twenty (20) or more patients are located within the facility, there shall be installed an approved fire alarm system.

P. If thirty (30) or more patients are located within the facility, all exit doors shall swing with exit travel and each exit shall be equipped with panic hardware.

Q. No inside dead-lock, bar, chain, or other device shall be installed on any exit door.

V. LOCAL FIRE CODE

Varies with each community- no uniform code throughout the state.

PROPOSED

(APPENDIX D-9)

STANDARDS FOR COMMUNITY VOCATIONAL-RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED

I. ADMISSION POLICY

The residential facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social and cognitive factors, conducted by an appropriately constituted interdisciplinary team. Residents must be admitted without regard to race, color, or national origin. Admissions will be limited to persons capable of learning social, vocational, and self-help skills, and demonstrate a potential for independent living. All admissions to the residential facility shall be considered temporary, up to a 2 year maximum stay, and on the basis of the comprehensive admission evaluation, a determination will be made within the two year maximum as to possible amount of time to be spent in the facility. Parents, guardians, or referral agencies having responsibility for the resident shall be encouraged to visit the facility prior to placement, relative advantages and disadvantages, and the temporary nature of the placement will be discussed to mutual satisfaction. The prospective resident will be given the opportunity of visiting the facility prior to actual placement.

II. RESIDENT LIVING

The residential facility must have an in-house habilitation or rehabilitation program for each resident to include, but not be limited to, training in money management, food preparation, laundry, personal hygiene, social skills, and planned group activities, designed to equip each resident with experience and behaviors required in normal everyday living. There must be specific program plans for each resident. The "rhythm of life" in the living unit shall resemble the cultural norm for the resident's non-retarded age peers. Residents shall be assigned responsibilities in the living units commensurate with their interests, ability, and developmental plans; birthdays and special events should be individually observed and provision shall be made for heterosexual inter-action appropriate to the resident's developmental levels. Residents should be instructed in the normal use of telephone, the mails, assumption of responsibility for personal possessions and they should be exposed to the usage of public transportation systems. Corporal punishment shall not be permitted

and residents shall not be involved in disciplining other residents except as it is a part of an organized self-government or management program that is conducted in accordance with written policy.

Residents' views and opinions on matters concerning them should be elicited and given consideration in defining the rules and regulations that affect them. There must be a written policy, and all members of the staff properly instructed on the use of restrictions, of punishments, and aversive techniques or negative reinforcement techniques used in behavior modification programs.

III. COMMUNITY SERVICES

A. Vocational Training

Vocational habilitation and rehabilitation services shall be available to the residents in accordance with their needs. Services for each resident will include vocational evaluation, the formulation of written vocational objectives, and a written plan for implementing the vocational plan through written agreements and statements of understanding with local training programs, sheltered workshops, and employers. Each resident will be fully involved in his vocational evaluation and in the formulation of his program. He shall be involved periodically in an evaluation of progress; the residential staff will work cooperatively with the vocational training agency to provide the resident with proper incentives and rewards.

B. Work Placement

The ultimate objective of vocational habilitation and rehabilitation services shall be to assist every resident to move as quickly as possible to remunerative employment and entry into the main streamline of society as an independent citizen and worker. To accomplish this objective, the residential facility must maintain an effective ongoing relationship with sheltered workshop programs, employment agencies and services and through community services initiate and maintain an ongoing effort to open additional suitable types of employment in both the private and public sector.

C. Independent Living

As the resident exhibits a readiness for independent living and upon the completion of a realistic period of successful job

performance, efforts will be made to obtain suitable independent living accommodations. This will be done by the residential facility staff working through the parents, the referring agency, and the resident. The resident will be encouraged to return to the residential facility for follow-up only as such services contribute to his eventual emancipation from the facility. If independent living proves to be unsuccessful, the resident will be permitted to return to the facility for additional training and eventual replacement in an independent living situation.

IV. MEDICAL AND DENTAL SERVICES

Medical services shall be available to the resident in order to achieve and maintain an optimum level of general health and well-being. Each resident will have had a medical examination not more than two weeks prior to admission. A medical examination will then be done on an annual basis. Arrangements will be made with the parents, the guardian or the referring agency having responsibility for the resident to arrange a plan of medical services. The facility may have arrangements with a local physicial to provide medical services for all the residents of the facility which may use a number of physicians in the community, or several physicians as designated by the families, or referring agencies of residents. The residential facility in its agreement with the parents, guardian or referral agency having responsibility for the resident will have proper authorization to provide both emergency and regular medical services, as needed, through one or more practicing physicians. The residential facility staff will have the responsibility of carrying out the physician's orders and instructions as though they were exercising a parental type of authority and responsibility. Medicines shall be kept in a secure and safe place until the resident demonstrates an ability to manage his own medication. Medical services and procedures normally requiring the supervision of a licensed qualified nurse will be obtained from appropriate community services. The facility will maintain records on each resident pertaining to immunization programs, illnesses, and accidents and injuries. Arrangements for hospital services will be made through the local physician in accordance with the medical service plan agreed upon for each resident at the time of admission.

Each resident will have had a dental examination within six months prior to or within thirty (30) days after admission. A dental examination will be done on an annual basis and dental services will be arranged through local dentists in accordance

with a written plan made at the time of admission with the facility, the parents, guardian or referring agency having responsibility for the resident. Written reports from the examining physician and dentist, as well as prescriptions, will be on file for each resident. Drugs will be administered only with written doctor's orders.

V. SOCIAL SERVICES

Social Services shall be available to all residents and their families in order to foster and facilitate maximum personal and social development for each resident, positive family functioning, and effective and satisfying social and community relationships. Social Services available to the facility will include pre-admission evaluation or counselling with reference to the use of other community resources, a psycho-social assessment of the individual resident and his environment as a basis for formulating an individual treatment plan and for planning for community placement, discharge and follow-up. Each residential facility must have the services of a qualified social worker. Qualifications may be individually determined in prorating training and/or experience in the field of mental retardation. The social worker may be a full time employee of the facility, he may be a part time employee of the facility on a contractual basis; or he may be made available to the facility through an agreement with an existing agency or service already providing services for the retarded in the community. The services of the social worker will be readily available on a planned and continuing basis. The social worker will have the responsibility of providing community services in the area of vocational habilitation and rehabilitation, work placement, and independent living. The social worker will have the responsibility of working with resident living staff in preparing programs, evaluations, and experiences relevant to developing appropriate and useful behaviors in preparation for normal community living.

VI. RECORD KEEPING

A record shall be maintained for each resident that is adequate for:

(a) Written documentation of the person and/or agency legally responsible for each resident;

(b) planning and continuous evaluating of the resident's habilitation program;

(c) providing a means of communication among all persons contributing to the resident's habilitation program;

(d) furnishing documentary evidence of the resident's progress and of his response to the habilitation program;

(e) serving as a basis for review, study, and evaluation of the overall programs provided by the facility for its residents;

(f) protecting the legal rights of the residents, facility and staff.

All information pertinent to the above stated purposes shall be incorporated in the resident's record, in sufficient detail to enable those persons involved in the resident's program to provide effective, continuing services. All entries shall be legible, dated, and authenticated by the signature and identification of the individual making the entry. Regular progress notes shall be entered into the record to insure adequate evaluation of progress. A formal statement of progress shall be made for each individual on a quarterly basis. A closing summary shall be entered into the record at the time of the person's release from the facility. A release plan in the closing summary shall include a description of follow-up services to be provided and an identification of the agency or individuals responsible for these follow-up services. All information contained in the resident's records shall be considered privileged and confidential.

VII. PERSONNEL STANDARDS

Within each community vocational residential facility for the mentally retarded, there shall be employed adequate personnel to provide the services as set forth and to insure the health and safety of the residents.

A. Every employee shall be of good character, physical and mental health, and shall demonstrate an ability to work with the mentally retarded.

B. Prior to employment, each employee shall have a physical examination including either a chest x-ray or tuberculin test and be free of any communicable or infectious disease. A physical will be required annually.

C. Prior to assuming duties in the facility, each employee shall engage in an inservice training program administered by the employer. This shall relate to the purpose of the facility, daily programming, resident evaluation, health and safety regulations, emergency policies, etc.

D. There shall be a written job description and personnel policies provided to each employee.

E. The employer shall adhere to the provisions of Title VI of the Civil Rights Act.

VIII. STAFFING

A. There shall be a Director of Residential Services who is responsible to the board of directors of the corporate agency for the functioning of the residential facility. The director of the corporate agency may serve as the director of residential services. Minimum qualifications for the director shall be a Bachelor's Degree with an appropriate major. A combination of training and experience with the mentally retarded may be substituted for this requirement. The director must also comply with any health certifications necessary for the licensing of the facilities.

Responsibilities of the director shall include:

1. Recruitment of qualified residential staff.

2. Supervision of residential staff and services.

3. Direction of resident movement in and out of the various community programs and the facility.

4. Solicitation and making agreements with private and public agencies for social services, job placement, etc., when facility does not employ specific personnel for such services.

5. Location of suitable housing, arrangement of maintenance, renovation, licensing, etc.

B. Two people (preferably married) shall serve as houseparents and reside in the home. They shall be responsible for

the household management and continuous family atmosphere. Only one parent may be permitted to continue to have community employment, but be expected to play a major role in the evenings and on the week-ends. One parent will be responsible for supervision of cooking of meals. Both parents will assist the residents in learning to perform household chores.

C. Two houseparents (preferably married) shall serve as a relief to the houseparents as scheduled. They shall assume all responsibilities as designated in (B).

D. Provisions shall be made for at least a part-time employee or volunteer who will assist in evening and week-end recreational activities and self-help skill training in the home.

IX. HOUSING *(HHF29)

1. There shall be no more than twenty (20) residents in the facility excluding staff.

2. The group home shall be residential appearing and shall be compatable with the surrounding homes within the community. The facility shall be sightly, both within and without, and shall provide reasonable comfort for all residents. Proximity to health hazards shall be avoided.

3. An easily accessible resident lounge (living room) area shall be provided in each home. In large facilities of two (2) stories it is desirable to have a lounge area on each floor. Hallways and corridors are not to be used as living or sleeping rooms.

4. The home shall provide a separate dining area adequate for seating all residents and personnel. (Living room and dining area may also be used for recreation.)

5. All exterior openings except approved fire exits shall be screened.

6. Residents occupying any bedroom shall be of the same sex except in the case of a room occupied by husband and wife.

7. The group home should have available a room and accessory facilities, including lavatory and water closet, which can be used for isolation of a resident or for a seriously ill person.

* Refers to sections of Health Facilities Regulations, State of Indiana, as effected June 30, 1970.

8. Residents shall not be required to pass through another resident room to reach a bathroom, living room, dining room, corridor or similar area. The Council may, for good reasons shown, waive the provisions of this regulation.

9. All rooms used for eating, living or sleeping purposes shall be provided with light and ventilation by means of outside windows with an area not less than one-eighth (1/8) of the total floor area of such room or rooms. Basement rooms shall not be used to house residents.

10. Natural lighting shall be augmented when necessary by artificial illumination of suitable intensity and quality to prevent eye strain and fatigue.

11. Each resident shall be furnished an individual bed, at least thirty-six (36) inches wide. The bed shall be furnished adequately with springs, clean mattress and sufficient clean bedding to keep the patient in decency and comfort. The bed linen shall be changed as necessary and at least once a week. Roll-away type beds, cots, or folding beds shall not be used.

12. An adequate individual dresser or a bedside cabinet with a hard surface shall be provided for each person.

13. Each bed shall have open access from one side. Bedrooms should contain no more than four (4) beds.

14. Not less than five hundred (500) cubic feet of air space shall be provided for each bed in any room where residents are housed. For purposes of this computation, maximum ceiling height is ten feet (10').

15. The home shall provide not less than fifty (50) square feet of usable floor area for each bed.

16. Whenever a person is kept in a single room, such room shall be not less than six feet (6') by ten feet (10') in size with a minimum ceiling height of eight feet (8').

17. Sub-ground level rooms used for resident occupancy shall have windows above ground level with sufficient lighting and ventilation.

18. All corridors used by residents shall have a minimum unobstructed width of three feet (3') and lighted properly at night and at other times when necessary.

19. Bedroom doors shall have no hardware that will allow the resident to lock himself in the room without emergency access by a staff member.

20. All construction shall be subject to the requirements of the building commissioner, fire commissioner and local codes.

21. If there are non-ambulatory residents, there must be provisions for ramps and elevators in multi-floored facilities.

X. TOILET AND BATHING FACILITIES (HHF30)

Adequate and proper inside toilet and bath facilities shall be provided as follows:

1. For each six (6) residents or major fraction in excess thereof, a minimum of one (1) water closet and one (1) lavatory for each sex.

2. One (1) bathtub or shower for each six (6) residents on each floor.

3. Toilets, baths or shower compartments shall be separated from all rooms by solid walls or partitions.

4. Rubber mats or other suitable safety measures shall be used in bathing facilities. Grab bars shall not be required but shall be recommended for at least one (1) tub or shower.

5. Each bathroom shall be well-lighted.

6. Water temperature for all bathing and handwashing facilities shall be controlled by approved antiscaled devices. Such devices may be individually or centrally installed.

7. The use of common towels, washcloths, or toilet articles is prohibited. Each home shall maintain towels, washcloths, and wearing apparel in satisfactory condition for each resident. In most cases, each resident may provide their own toilet articles as a training effort.

8. Toilet and bathroom doors shall have no hardware that will allow a resident to lock himself in the room without emergency access by a staff member.

9. There shall be individual racks or other drying space for washcloths and towels.

10. At least one (1) lavatory shall be accessible to and usable by residents in wheelchairs, only as necessary.

XI. WATER AND SEWAGE (HHF31)

1. The home shall use an approved public water supply if available. Water service shall be adequate and shall be brought into the building in accordance with local requirements and be free of cross connections.

2. If a private water supply is used, the health facility shall comply with appropriate Board regulations.

3. Sewage shall be discharged into an approved public sewage system where such system is available; otherwise, the sewage shall be collected, treated and disposed of in an independent system which complies with the requirements of the Board.

XII. CONSTRUCTION, ALTERATION OR ENLARGEMENT (HHF32)

1. All construction, alteration or enlargement of health facilities shall comply with the rules and regulations of the Administrative Building Council.

2. For alteration and remodeling projects involving less than thirty-thousand (30,000) cubic feet or less than ten-thousand dollars ($10,000) in cost, suitable detailed plans and sketches are sufficient.

3. Plans for all new construction must be certified by an architect or an engineer registered in the State of Indiana.

4. All plans shall be submitted, before construction is started, to the State Fire Marshal, State Board of Health, and Administrative Building Council for approval.

5. Health facilities shall be located in or near a community which can provide the necessary supportive services for

the home such as fire protection, medical services, public utilities, and be located on a well-maintained all weather road.

XIII. FOOD SERVICE (HHF33)

1. General

Food served to residents each day shall be sufficient in quality and quantity to meet individual nutrition needs. The current Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council with consideration given to age, sex, activity and medical condition shall be the standard used for the evaluation of the normal and therapeutic diets provided.

a. A written menu for patients and residents shall be prepared at least a week in advance. The menu specifically shall name each kind of food and the method of its preparation.

b. A dated menu for the current week shall be kept in an accessible place in the main kitchen and in any serving kitchens or other areas used by employees purchasing, preparing and serving food.

c. Dated menus shall be kept on file for one (1) year as a reference for personnel in the health facility and the Board.

d. All foods shall be prepared by methods that conserve nutritive value, flavor and appearance.

e. Tested recipes appropriate for the size of the facility shall be kept on file and used in the preparation of the foods listed on the menu.

f. Nutritive concentrates or supplements shall be given only on a written order by a physician.

2. Diets

All diets served in a home shall be prescribed by the physician with a written order in the patient's record. Therapeutic diets which are part of medical treatment shall be correctly served as prescribed.

a. Diet orders shall be reviewed and rewritten by the physician at least once every six (6) months.

b. An approved diet manual shall be provided at convenient locations for use of physicians writing orders; and for use of food service and nursing personnel responsible for planning, preparing and serving therapeutic diets.

c. A correctly written menu plan for therapeutic diets shall be posted in the food preparation area. Such menus shall be kept on file for at least one (1) month after being served.

3. Service

a. Tables of suitable height and construction so as to accommodate wheel chairs shall be available as necessary.

b. All food shall be served neatly, attractively and at proper temperature.

4. Mean Hours

a. Three (3) well planned meals shall be provided at regularly scheduled hours. The residents shall be provided with a sack lunch for the noon meal unless they are served a noon meal at the rehabilitation center or job. The evening meal and the succeeding breakfast shall be served no more than fourteen (14) hours apart.

5. Food Supply

a. There shall be kept available in the home a minimum of a twenty-four (24) hour supply of perishable foods and a three (3) day supply of nonperishable foods to meet the requirements of the planned menu.

b. A store of canned or processed meats, fish, fruits, fruit juices and vegetables shall be available to serve the residents a nutritionally adequate diet for at least three (3) days in case of an emergency.

6. Food Service Personnel

The houseparents shall supervise the residents in the preparation of food as part of the rehabilitation program within the home. A resident work schedule shall be posted.

XIV. FACILITIES AND METHODS (HHF34)

1. Food Service

a. The food preparation and serving areas including the structure, construction and installation of all equipment and facilities shall meet the minimum sanitation requirements as provided in State Board of Health Regulation HFD 17.

b. Adequate and conveniently located refrigeration and hot food storage and display facilities shall be provided and used as needed to assure the maintenance of readily perishable or potentially hazardous food at temperature of forty-five degrees Fahrenheit (45^{0} F.) or below or one-hundred and forty degrees Fahrenheit (140^{0} F.) or above during storage, display and service. Frozen foods shall be stored at zero degrees Fahrenheit (0^{0} F.) or below. Each facility used for the storage of hot or cold food shall be provided with an indicating thermometer accurate to plus/minus two degrees Fahrenheit ($\pm 2^{0}$ F.); the thermometer shall be located in the critical temperature zone of each facility in which food is stored and shall be of such type and so situated that it can be readily observed.

c. An adequate food storage space shall be provided and shall be clean and well-ventilated. All food shall be stored off the floor and shall be protected from dust, flies, rodents, insects, unnecessary handling, overhead leakage, or other sources of contamination.

d. Two-compartment dishwashing sinks, which are presently installed, may be used provided they are of easily cleanable construction, are of adequate size and depth, are equipped with adequate drainboards, and are supplied with hot and cold running water. At least one (1) three-compartment sink, in compliance with applicable specifications of the National Sanitation Foundation, shall be installed in all new construction

including remodeling and replacement of existing sinks, provided a manual dishwashing method is to be used.

e. Sinks used for manual washing and sanitizing operations shall be of adequate length, width and depth to permit the complete immersion of the utensils and equipment. Dish baskets shall be of such design as to permit complete immersion of the utensils and equipment components being sanitized therein.

f. All utensils, equipment and vegetable sinks shall be constructed of smooth, noncorrosive material, suitably reinforced of such thickness and design to resist denting and buckling, and free from open seams; and such compartment shall be supplied with hot and cold running water under pressure.

g. The end compartments shall be provided with integral drainboards of adequate size, for proper handling of soiled utensils prior to washing and for cleaned utensils following rinsing or sanitization, and graded to drain into the sink: provided, that drainboards shall not be required for utility or vegetable sinks.

h. When utensils and equipment are washed and sanitized manually, the following additional requirements shall be met:

(1) Prior to washing, all equipment and utensils are preflushed or prescraped and, when necessary, presoaked to remove gross food particles and soil.

(2) Effective concentrations of a suitable detergent are used.

(3) When hot water is used as the sanitizing agent, thermometers or thermostatic controls, accurate to plus/minus two degrees Fahrenheit ($\pm 2^{0}$ F.), are provided convenient to the sink to permit frequent checks of the water temperature and to aid in maintaining effective water temperature.

(4) Multi-use utensils and equipment are thoroughly washed in a detergent solution in the first compartment of

the sink which is kept reasonably clean, and then are rinsed of such solutions in the second compartment of the sink. All eating and drinking utensils and, where required, the food-contact surfaces of all other equipment and utensils are sanitized in the third compartment by one (1) of the following methods: Immersion for at least two (2) minutes in clean hot water at a temperature of at least one-hundred and seventy degrees Fahrenheit (170° F.), which is maintained at such temperature by a booster heater or other effective means; or immersion for at least two (2) minutes in a sanitizing agent which has been demonstrated to the satisfaction of the health officer to be effective and non-toxic under use conditions, and for which a suitable field test is available.

(5) Utensils and equipment are removed from the one-hundred and seventy degrees Fahrenheit (170° F.) water or chemical sanitizing solution and allowed to air dry prior to storing them in a clean and protective place.

i. Spray-type dishwashing machines shall be provided and used wherever washing and sanitizing of equipment and utensils are conducted mechanically: provided that immersion-type dishwashing machines may be used in place of spray-type machines, if they comply with the applicable requirements of Item h above, and the wash water is maintained at or above one-hundred and forty degrees Fahrenheit (140° F.).

j. Dishwashing machines shall be of such materials and so designed and constructed as to be easily cleanable, and shall be capable, when operated properly, of rendering all surfaces of equipment and utensils clean to sight and touch, and sanitized.

k. When spray-type dishwashing machines are used, the following additional requirements shall be met:

(1) Prior to washing, all equipment and utensils are preflushed or prescraped and, when necessary, presoaked to remove gross food particles and soil.

(2) Effective concentrations of a suitable detergent are used.

(3) Wash water is kept reasonably clean, and rinse-water tanks are so protected by distance, baffles, or other effective means as to minimize the entry of wash water into the rinse water.

(4) The flow pressure is maintained at not less than fifteen (15) or more than twenty-five (25) pounds per square inch on the water line at the machine, and not less than ten (10) pounds per square inch at the rinse nozzles. A suitable guage is provided immediately upstream from the final rinse sprays to permit checking the flow pressure of the final rinse water.

(5) The wash-water temperature is maintained at least one-hundred and forty degrees Fahrenheit (140° F.) and in single-tank conveyor machines at least one-hundred and sixty degrees Fahrenheit (160° F.). When hot water is relied upon for sanitization, the final or fresh rinse water is maintained at a temperature of at least one-hundred and eighty degrees Fahrenheit (180° F.) at the entrance of the manifold. When a pumped rinse is provided, the water is maintained at a temperature of at least one-hundred and seventy degrees Fahrenheit (170° F.).

(6) Conveyors in dishwashing machines are accurately timed to assure proper exposure times in wash and rinse cycles.

(7) An easily readable thermometer is provided in each tank of the dishwashing machine which indicates to accuracy of plus/minus two degrees Fahrenheit ($\pm 2^{\circ}$ F.) the temperature of the water or solution therein. In addition, a thermometer of equal accuracy is provided which indicates the temperature of the final rinse water as it enters the manifold.

(8) Jets, nozzles, and all other parts of each machine are maintained free of chemical deposits, debris, and other soil. Automatic detergent dispensers, if used, are kept in proper operating condition.

(9) Dishes and other utensils are removed from the machine and allowed to air dry prior to storing them in a clean protective place.

1. Any other type of machine, device, or facilities and procedures may be approved by the Board for cleaning or sanitizing equipment and utensils, if it can be readily established that such machine, device or facilities and procedures will routinely render equipment and utensils clean to sight and touch, and provide effective bactericidal treatment.

m. Adequate handwashing facilities shall be provided convenient to all areas where the nature of the work necessitates frequent washing of the hands. Handwashing facilities shall include a lavatory with hot and cold running water, soap and individual towels. Common towels shall not be used.

n. Disposal of Wastes

Proper disposal of all liquid wastes shall be accomplished. All garbage shall be flushed through a mechanical garbage disposal unit or kept in tightly covered, nonabsorbent containers pending removal. Trash shall be kept in suitable receptacles in such a manner as not to be a nuisance or fire hazard.

o. Insect and Rodent Control

All means necessary to eliminate and prevent the entrance of flies, roaches, and rodents shall be used. Adequate screens shall be provided for outer openings. All poisonous compounds used in the extermination of rodents or insects shall be so colored and labeled as to be easily identified and shall be stored separately from foods.

p. Wholesomeness of Food

All food shall be clean, wholesome, free from spoilage and so prepared as to be safe for human consumption. All milk, milk drinks, cream, ice cream, and other frozen desserts shall be from a Grade A pasteurized source.

q. Food Handlers

All employees shall wear clean garments and shall keep their hands clean at all times while engaged in handling food, utensils, or equipment. Employees shall not smoke while engaged in preparation or serving of foods.

2. Laundry

The health facility shall be equipped with the necessary laundry facilities or satisfactory arrangements shall be made for linen to be sent to a commercial laundry. A suitable room with proper equipment should be designed as a laundry. All areas used in preparation, storage, and serving of food shall be protected from the laundry area. Provision shall be made for suitable storage of soiled linen.

3. Janitor

There shall be a janitor's sink and a closet for cleaning supplies located as conveniently as possible for efficient use.

XV. DRUG HANDLING (HHF35)

Medications shall be kept in secure and safe locations until resident demonstrates ability to manage own medications.

XIV. FIRE SAFETY STANDARDS

Regulations as stipulated by the Indiana State Fire Marshal.

(APPENDIX E-1)

HOUSE ENROLLED ACT NO. 1145

AN ACT to amend IC 1971, 16-15 by adding a new chapter concerning residential placement and services as an alternative to institutionalization of the mentally retarded.

WHEREAS, Often institutionalization is not the most appropriate means of care for a mentally retarded individual when the family or guardian can no longer care for the individual,and

WHEREAS, Present funding limits alternate care before placement in a district hospital operated by the Department of Mental Health: Therefore

BE IT ENANCTED BY THE GENERAL ASSEMBLY OF THE STATE OF INDIANA:

SECTION 1. IC 1971, 1615 is amended by adding a new chapter to be numbered 1.5 and to read as follows:

Chapter 1.5 Residential Placement

Sec. 1. The Superintendent of a district hospital authorized to care for the mentally retarded is hereby authorized to place in a residential facility, as approved by the Department of Mental Health, any person for whom application for admission has been made and who is eligible for immediate residential services in that hospital.

Sec. 2. The Department of Mental Health shall publish guidelines which shall determine criteria for eligibility, placement, funding and other issues pertinent to the implementation of this chapter.

(APPENDIX E-2)

HOUSE ENROLLED ACT NO. 1213

AN ACT to initiate the development of demonstration community residential models for the mentally retarded

WHEREAS, The State of Indiana is striving to provide a most adequate system of programming for the mentally retarded; and

WHEREAS, Placement of a mentally retarded individual by the Department of Mental Health in one of the state institutions is often not in the best interest of the individual for potential growth: Therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLE OF THE STATE OF INDIANA:

SECTION1. It is the intent of the State of Indiana to develop through leasing a variety of needed community residential facilities.

SECTION2. Priority for placement in these model facilities shall be given to residents at Muscatatuck State Hospital and Training Center, Fort Wayne State Hospital and Training Center and Northern Indiana Children's Hospital.

SECTION3. The findings of the present study being conducted by the Indiana Mental Retardation Residential Services Planning Project shall be utilized in selecting the communities and types of facilities to be established.

SECTION4. The Superintendents of state hospitals and training centers shall enter into agreements on the development and administration of these facilities with community organizations. The Department of Mental Health shall set forth eligibility regulations for these organizations as well as serve as the evaluative and responsible agency for the purpose of this chapter.

SECTION5. This Act shall take effect July 1, 1972.

(APPENDIX E-3)

SENATE ENROLLED ACT NO. 149

AN ACT to amend IC 1971, 12-1 by adding a new chapter concerning the Department of Public Welfare, the Department of Mental Health, the Board of Health, the Department of Corrections, Department of Public Instruction and the Social Security Act.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF INDIANA:

SECTION 1. IC 1971, 12-1 is amended by adding a new chapter to be numbered 2.5 and to read as follows:

Chapter 2.5 Guildelines for use with Social Security Act.

Sec. 1. In order to provide maximum services to the mentally retarded, the mentally ill and individuals who are former, actual or potential welfare recipients and to provide maximum efficiency in the use of state dollars allocated for such purposes, and to secure to the State of Indiana and local units of government the maximum participation in the benefits of the Federal Social Security Act as provided in IC 1971, 12-1-13 the Department of Public Welfare shall adopt the following provisions in the administration of Titles I, IV-A, X and XIV of said federal act.

Sec. 2. Services under Titles I,X, and XIV shall include but not be limited to the following:

(a) Homemaker services
(b) Family counseling and treatment, including marital counseling
(c) Adult foster home placement and evaluation
(d) Day care (group-family-own home) including day care for the mentally handicapped
(e) Protective services
(f) Vocational training and counseling and social services to enhance potential for self-support
(g) Counseling on use of recreational facilities and payments for use of such facilities when not otherwise available
(h) Consultation services for the purpose of assisting the agency as necessary in developing service plans
(i) Services to enable persons to return to or remain in their own homes or communities

Sec. 3. Services under Title IV-A shall include but not be limited to:

(a) Day care (group-family-own home) including day care for the mentally handicapped

(b) Homemakers
(c) Vocational training and counseling and social services to enhance potential for self-support
(d) Educational services
(e) Casework counseling and treatment, including services to unmarried parents.
(f) Family counseling and treatment, including marital counseling, counseling in child care and rehabilitation of families with children in foster or institutional care.

Sec. 4. In accordance with the Social Security Act and its amendment eligibility for these title programs shall be by determination of the individual as a former, actual or potential welfare recipient as defined by the Social Security Act, and no means test shall be applied.

Sec. 5. In order to carry out the intent of this chapter for maximum services to the mentally retarded, the mentally ill and potential welfare recipient, the state department of public welfare shall contract with the department of mental health, the department of corrections, the department of public instrction and the board of health to insure the full use of state funds.

Sec. 6. The department of mental health shall be authorized to accept monies from the counties and/or voluntary agencies to provide for maximum use of state dollars for the mentally ill and the mentally retarded. A special fund shall be established within the department of mental health to receive these funds. These state and local funds shall be used for the purpose of meeting the state and local share of cost in purchasing of care and services for the mentally ill and the mentally retarded.

Sec. 7. The state department of public welfare shall contract to the department of mental health, department of corrections, the department of public instruction and the board of health the right to disburse these funds and the matching federal dollars for the purchase of care and services to the mentally retarded and the mentally ill to agencies approved by those departments. These agencies may be other state, local or not-for-profit corporations.

Sec. 8. The division of services to families and children, the crippled children's division and the division for assistance to the totally and permanently disabled persons of the department of public welfare shall meet periodically with the appropriate divisions of the department of mental health, the department of corrections, the department of public instruction and the board of health to see that maximum dollars and services are being utilized in Titles I, IV-A, X and XIV with regard

to those services contracted for under the provisions of this chapter. The commissioner of mental health and the director of public welfare may appoint others to attend those meetings if it is in the interest of the mentally retarded and/or the mentally ill.

Sec. 9. The state department of public welfare shall alter the present state plan for Titles I, IV-A, X and XIV to provide for the above and shall make what other changes are necessary to keep these titles in compliance with the federal regulations.

Whereas an emergency exists for the immediate taking effect of this act, the same shall be in full force and effect from and after its passage.

APPENDIX F-1

GUIDELINES FOR THE DEVELOPMENT OF A COMMUNITY RESIDENTIAL FACILITY

FOREWORD

The Indiana Mental Retardation Residential Services Planning Project recognizes that with complementary programming such as education and vocational training, etc., the small group home, foster care, apartment living and other community based programs are the most humanistic living arrangement for the greater portion of those retarded who require some type of supervised living.

Within the duration of the project, Steering Committee members and staff have been actively engaged in visiting and reviewing existing community facilities across America and in Europe, as well as discussing with personnel and residents the many advantages and obstacles that have developed in the programs. Therefore, even though not all is known, it is believed that further insight and precautionary measures should be shared with the agencies who may be contemplating the initiation of a residential program. A major reference and possible standards source is the Standards for Residential Facilities for the Mentally Retarded as published by the Joint Commission on Accreditation of Hospitals.

I. PRINCIPLES

Because the retarded are first and foremost citizens, they are entitled to those services which will help them attain their maximum potential.

The concept of "normalization" as advocated includes letting the mentally retarded obtain an existance as close to normal as possible. Stated another way, we can say that as much as possible, retarded persons should be treated as ordinary persons of their age in the community. The most favorable environment for the growth and development of the large majority of mentally retarded children is with their own families, in specialized residential facilities, or in foster homes in the community. Every mentally retarded child should be with his own family until he reaches adulthood unless he imposes an undue burden upon them.

Walter B. Williston, Q.C.,[1] formalizes a philosophy on residential care as:

"In order to avoid the institutionalization of a mentally retarded child, the first step is to encourage and assist the parents to keep the child at home. Help should be offered where the problem begins in the home. It is the right and the primary

[1] Williston, Walter, Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario, August 1971, Ontario Department of Health.

responsibility of parents to care for their children. This equally applies if the child is handicapped, although the problems are infinitely more difficult and complex. The needs of every child, be he normal or handicapped, are basically the same. They are: family ties, love, emotional warmth, understanding and acceptance. There must be growth of his social, physical and emotional resources to prepare him for the future. The best place for the child to receive such essentials is in a healthy home environment. This statement, however, is subject to the following qualifications:

A. The parents must be provided with the necessary support services. If these services are not provided and the child is forced to spend a large part of his time at home, he will in all likelihood suffer from overprotection and overnurturing, (and other members of the family may lack proper attention.)

B. There are certain homes where the environment is not satisfactory.

C. In the case of the profoundly or severely or multiply handicapped, it might be too much to ask the parents to keep the children at home.

D. In certain cases there may be behavioural or emotional problems which need expert care and assistance.

When a retarded child reaches adulthood he should ordinarily be expected to leave home the same way as any other child. It is not good for the retarded person to live at home indefinitely where he will be consistently held in the attitude of a child. If he does not leave home when he reaches maturity, it can be very destructive to the family. The parents become increasingly anxious about what will happen to their child when they die or cannot keep him any longer. A moderately mentally retarded adult should be in a sheltered home close to a sheltered workshop. It is preferable that he makes his break while his parents are still alive so that they can give him the support he needs. The transition can be made without trauma to anybody. It will alleviate the financial and mental burden on the family if its members can see their mentally retarded relative is adjusting to society outside of the parental home. Thus the range of services in the community must be such that the family can be certain that their retarded member will be properly looked after when he leaves home. It becomes almost necessary that in the range of services there be some guardianship arrangement made with a trustworthy person or agency."

II. PRIORITIES

Persons interested in the development of residential care services should undertake careful planning to determine the need for residential services in their community. There should be a determination as to the exact financial ability and responsibility of families and other agencies that will be assumed in the placement of a retardate in a facility.

Sources of funding for individuals would possibly include local and state welfare, social security benefits and trust funds, Division of Vocational Rehabilitation funds, Family Care and Department of Mental Health funds, as well as federal staffing grants. As a rough estimate of residential need, 1/10 of 1% of the population needs such service at any given time. It will probably be easiest to start with the population for which there is appropriate community services, and in which staffing for residential care will be minimal.

III. STRUCTURE

The developmental needs of the retarded and his family should determine the choice of residential structure. Before finalizing the plans for construction, rental, purchase, or lease of a home or apartments, consult with an engineer(s) or architect(s). Clarify from the beginning that:

1) Construction must meet all state and local code requirements,

2) that the architect and/or engineer must be ready to assist you in what may be confusing or arbitrary decisions by one or more of the regulatory agencies,

3) that costs are important and that the agency has a responsibility to obtain the best cost-benefit ratio by holding down cost with #1 and 2 above, and

4) that the facility should be kept as "homelike" as possible; remember the structure is not being used for a school or hospital, but a HOME.

A. Administrative Building Code

Personally contact both state and local building code officers for official recommendations and final approval of the building or remodeling. Have this material in writing.

B. Fire Code

Same as above with State and local Fire Marshall's office.

C. Zoning Regulations

There are no uniform state regulations regarding zoning. Contact will be necessary with the local board. Two important factors to consider, especially if modification in zoning regulations are being requested.

1. Prior relationships with officials who will approve or disapprove the request.

2. Ability to convince the neighbors that (a) your project will help them or at least, (b) it will not hurt them.

D. Licenses

1. If residents are under the age of 18, licensing must be obtained by the State Department of Public Welfare.

2. If residents are above age 18 and plans are to include patients from one of the state hospitals on Family Care, approval must be received from the Department of Mental Health.

3. If serving those above 18 and none from (2), no licensing is currently necessary. However, there is a committee of the Health Facilities Council currently studying the need for a special category of regulations for community residential facilities for the retarded.

IV. COSTS

If building, cost consideration must be given to purchase of land, mortgage and debt financing, architectural and legal fees, etc. When purchasing, renovating to meet state standards may be quite costly. Be sure money is readily available before beginning the project. Give equally strong consideration to renting or leasing as alternatives. Operational costs will vary according to the clientele and their personal and programmatic needs. A brief description of the various types of residential models is on Page 13 and Page 14 of project report. The regional system in Omaha, Nebraska operates small group homes with budgets ranging from $11,687 to $35,780 yearly. A sample budget is at the end of the Guidelines to demonstrate the many areas of costs. If a profit corporation were operating a program, real estate tax, state sales tax, and profit margin would have to be additionally considered. It is understood that additional staff will be necessary for younger and more severely retarded, thus increasing the cost of operation. Property costs will also vary among the communities. The debt on construction and land will create an

increase in costs per year.

There is a need for an overview which presents the broad outline of the combinations of services plus residential facilities. The following chart is such an attempt. It does not include all essential services, such as counselling, medical, dental, etc.

EXAMPLES OF SERVICE REQUIREMENTS

	MILD	MODERATE	SEVERE	PROFOUND
AGES 0-5+	1. Pre-school Training 2. Transportation 3. Residential a) Family b) Foster	1. Pre-school Training 2. Transportation 3. Residential a) Family b) Foster c) Crisis or Respite	1. Pre-school Training 2. Transportation 3. Residential a) Family b) Foster c) Crisis or Respite d) Developmental Home e) Special Facility	1. Behavior Shaping 2. Transportation 3. Medical 4. Residential a) Family b) Foster c) Crisis or Respite d) Developmental Home e) Special Facility f) Maintenance of Life
AGES 6-17	1. Public School a) Primary b) Intermed. c) Pre-voc. d) Vocational 2. Recreational 3. Transportation 4. Residential a) Family b) Foster	1. Public School a) Primary b) Intermed. c) Pre-voc. d) Vocational 2. Recreation 3. Transportation 4. Residential a) Family b) Foster c) Crisis or Respite	1. Public School a) Primary b) Intermed. Activities of Daily Living 2. Recreation 3. Transportation 4. Residential a) Family b) Foster c) Crisis or Respite d) Educational Group Home e) Special Facility	1. Self-help, Self-skill 2. Activities of Daily Living 3. Medical 4. Transportation 5. Residential a) Family b) Foster c) Crisis or Respite d) Educational Group Home e) Special Facility

(APPENDIX F-6)

	MILD	MODERATE	SEVERE	PROFOUND
AGES 18-25	1. Vocational Training 2. Employment a) Sheltered b) Competitive 3. Recreation 4. Transportation 5. Residential a) Family b) Foster c) Crisis or Respite d) Semi-indep.	1. Vocational Training 2. Employment a) Sheltered b) Competitive 3. Recreation 4. Transportation 5. Residential a) Family b) Foster c) Crisis or Respite d) Voc. Home	1. Work Activity-Pre-voc. Trng. 2. Recreation 3. Transportation 4. Residential a) Family b) Foster c) Crisis or Respite d) Pre-voc. Self-esteem e) Special Facility	1. Self-help, Self-skill 2. Activity Center 3. Transportation 4. Residential a) Family b) Foster c) Crisis or respite d) Self-esteem e) Special Facility
AGES 26-50	1. Adult Educ. 2. Employment 3. Job Upgrading 4. Recreation 5. Residential c)Crisis d)Semi-Independent	1. Adult Education 2. Employment 3. Job Upgrading 4. Recreation 5. Residential c) Crisis d) Vocational or Semi-Independent	1. Special Skill or Voc. Training 2. Transportation 3. Recreation 4. Residential c) Crisis d) self-esteem	1. Self-help 2. Activity Center 3. Transportation 4. Residential d) self-esteem e) special unit
AGES 50+	1. Employment 2. Recreation 3. Residential c) Crisis d) Semi-indep.	1. Employment 2. Recreation 3. Residential d)and e)	1. Work Activity 2. Recreation 3. Transportation 4. Residential d)and e)	1. Self-help 2. Recreation 3. Residential d) and e)

APPENDIX F-7)

SAMPLE PLANNING BUDGET FOR

COMMUNITY RESIDENTIAL FACILITY FOR SIX PERSONS

HOUSING	CAPITAL INVESTMENT	MONTHLY COST	ANNUAL COST
Housing (appros. 4 bedrooms, 8 rooms and basement) including land	*$42,000.	$401.	$4817. (15 yr. loan at 8%)
Furnishings and equipment (est. $1,000 per room)	$ 8,000.(cash or bank loan)		
Heat		$ 20.	$ 240.
Electricity		$ 20.	$ 240.
Water		$ 15.	$ 180.
Telephone		$ 12.	$ 144.
Repairs and Maintenance (2½%)		$ 88.	$1050.
Repairs and replacement of furniture (10 yrs. life or 1/10 of $8,000).		$ 67.	$ 800.
Household Supplies		$ 35.	$ 420.
Insurance (house contents, liability, group life)		$ 63.	$ 750.
MANAGEMENT			
Live in houseparents (couple) receives room, board, 1 wk. vacation		$400.	$4800.
Relief parents for equiv. 2 days per wk. 24 hrs.-$16. per day 111 days		$148.	$1776.
Third level management, if needed		$240.	$2880.

* If any part of the $42,000 is paid in cash, yearly and monthly costs would be reduced. At the end of 15 years, the building will be owned.

(APPENDIX F-8)

PERSONAL LIVING	CAPITAL INVESTMENT	MONTHLY COST	ANNUAL COST
Food, $1.50 per person daily (8 people)		$364.	$4368.
Clothing for 6 ($15. per mo. each)		$ 90.	$1080.
Medical (group plan) $150. x 8=$1200		$100.	$1200.
Physical (outpatient) $50.x6		$ 25.	$ 300.
Dental $40.x6		$ 20.	$ 240.
Optical $40.x6		$ 20.	$ 240
Sundries (hair cuts, cigarettes, etc.) $8. per month		$ 48	$ 576.
Recreation, entertainment ($1. per day per person)		$183.	$2190.
TRANSPORTATION			
To and from work, recreation, etc. (9 passenger van)	$3,800	or payment to another source	
Repairs, ins., gas, oil		$ 70.	$ 840.
Replacement fund 12,000 miles (7¢ per mile)		$ 70.	$ 840.
MISCELLANEOUS AND EMERGENCY	10%		$2835.
	$53,800.	$2499.	$32,806.

* Note: This does not include fees for daily community programs, nor administrative costs.

"The grim struggle for survival does not allow

us the luxury of wasting our human resources."

John F. Kennedy

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